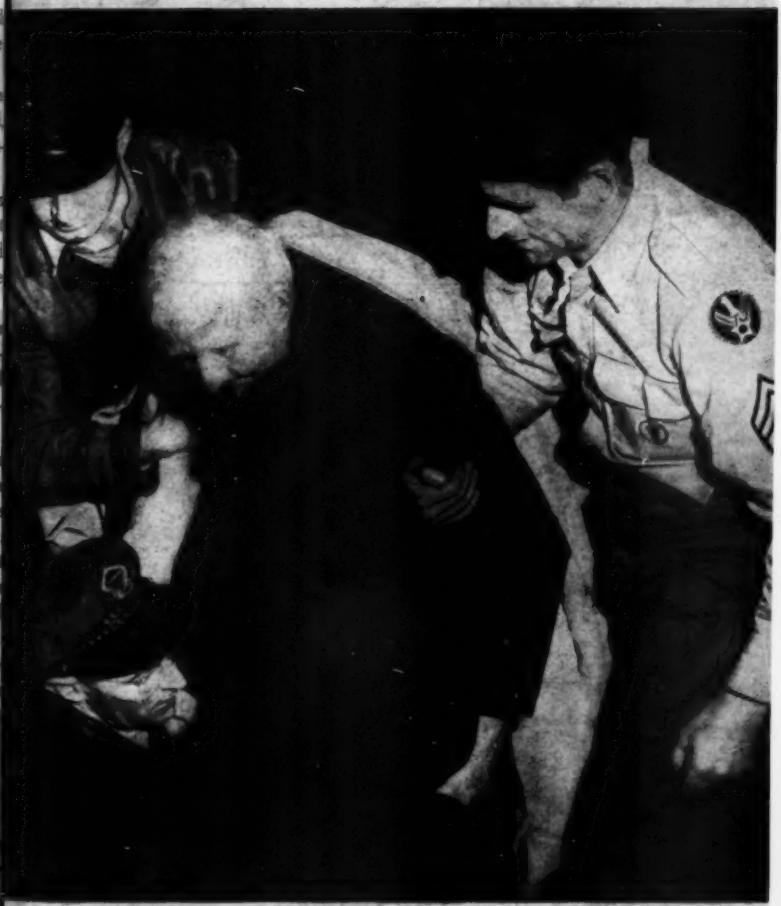
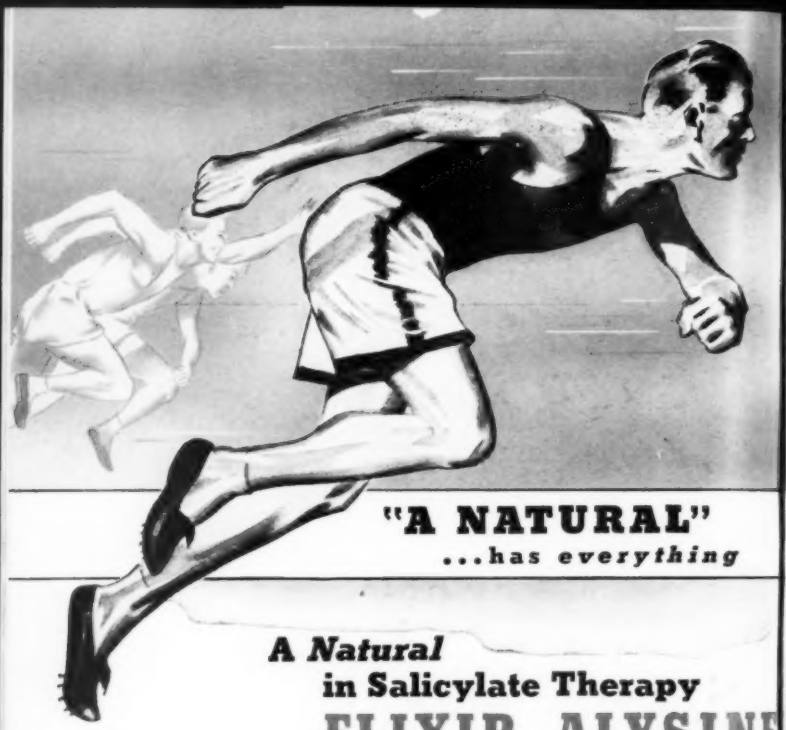
February

Medical Economics



• War Plans for Civilian Medical Care Lag • Page 55



"A NATURAL"
...has everything

A *Natural* in Salicylate Therapy

ELIXIR ALYSINE

A Distinctive Combination of Merrell's Natural Salicylate and Alkaline Salts

MERRELL'S NATURAL SALICYLATES
PREPARED SOLELY FROM OIL OF SWEET BIRCH

Elixir Alysine, containing approximately 0.3 Gm. (5 grs.) natural sodium salicylate and 0.6 Gm. (10 grs.) alkaline salts per teaspoonful, in 4-oz., pint and gallon bottles.

Also available as

Alysine Powder, containing approximately 0.6 Gm. (10 grs.) natural salicylates and 1.2 Gm. (20 grs.) alkaline salts per level teaspoonful, in 1-oz., 4-oz., and 1-lb. bottles.

In the symptomatic treatment of the common cold, influenza, la grippe, tonsillitis, rheumatic fever and arthritis, Elixir Alysine is the *natural* choice.

Containing *natural* salicylates prepared solely from oil of sweet birch, together with selected alkaline salts, Alysine provides fast, intensive salicylization with a minimum of gastric irritation or systemic acidotic tendency.

In a palatable, aromatized solution, Elixir Alysine is immediately assimilable for quick therapeutic response and readily adaptable to fractional dosages.

Used adjunctively with the sulfas, Alysine provides an alkaline (tolerance) factor, and at the same time helps to relieve muscular aches and pains.

Trademark "Alysine" Reg. U. S. Pat. Off.

MERRELL
1828

THE WM. S. MERRELL COMPANY • CINCINNATI, U.S.A.

Medical Economics

* * * *February 1948* * * *

[CONTINUED ON FOLLOWING PAGE]

CONTENTS (*Cont.*)

Editor-in-Chief, H. Sheridan Baketel, M.D. *Editor, William Alan Richardson. Associate Editors, Edmund R. Beckwith, Jr. and R. Cragin Lewis. Publisher, Lansing Chapman. Business Manager, W. L. Chapman, Jr. Sales Manager, R. M. Smith.* ☆ *Copyright 1948, Medical Economics, Inc., Rutherford, N.J. 25c a copy, $3 a year (Canada and foreign, $3.50). Circulation: 135,500 physicians, residents, and internes.* ☆ PICTURE CREDITS: *Cover, International; 44, 45, N.Y. Daily News; 46, 47, This Week; 54, Underwood; 55, Acme; 56-57, International, British Combine; 59, International, Acme; 61, International; 70, Marcello.*

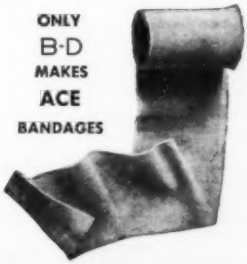
The unique B-D weave combined with Lastex* yarn controls the ACE *Reinforced* (No. 8) elastic bandage, permitting it to stretch just slightly more than twice its length . . . Laboratory tests have shown that this *controlled stretch* of an ACE *Reinforced* elastic bandage gives full support without inhibiting normal circulation.

The ACE *Reinforced* elastic bandage has *ALL* the advantages of rubber elastic bandages, PLUS *controlled stretch.* Lastex yarn is comparatively unaffected by perspiration, oil, grease and solvents that may shorten the life and reduce the therapeutic value of rubber reinforced bandages.

*® U. S. Rubber Co.

B-D PRODUCTS
Made for the Profession

ONLY B-D MAKES ACE BANDAGES



BECTON DICKINSON & CO.

RUTHERFORD, N. J.

44...

OF NEMBUTAL'S CLINICAL USES

SEDATIVE

Cardiovascular
Hypertension[2]
Coronary disease[2]
Angina[1]
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[2,3]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[5,6]

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[2]

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

PEDIATRIC
Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Nembutal alone or [1]Glucophylline® and Nembutal, [2]Nembutal and Belladonna, [3]Ephedrine and Nembutal, [4]Nembudeine®, [5]Nembutal and Aspirin, [6]with scopolamine or other drugs.

Many and varied, too, are the uses of short-acting Nembutal. Since it may now be your barbiturate of choice in one or more conditions, perhaps you have considered the advantages of enlarging your experience with Nembutal in other conditions—as more and more physicians are doing. • Their rationale is sound. They are familiar with the doses needed to achieve any desired degree of cerebral depression, from mild sedation to deep hypnosis. They know that the dosage required is small, about *one-half* that of many barbiturates . . . that, with this small dosage, the duration of effect is shorter . . . the amount of drug to be inactivated is less . . . the possibility of after-effect is reduced . . . and the margin of clinical safety is wide. • In cases where Nembutal is indicated, won't you give it a trial in conditions besides those for which you are now using it? There are 11 Nembutal products available at your pharmacy, all in convenient small-dosage forms. ABBOTT LABORATORIES, North Chicago, Illinois.

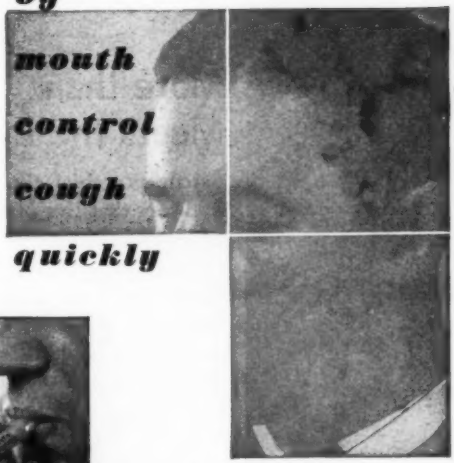
In equal oral doses, no other barbiturate combines* QUICKER, BRIEFER, MORE PROFOUND EFFECT *than

Nembutal®

(Pentobarbital Sodium, Abbott)

HAVE YOU TRIED *Nembutal Sodium Suppositories, or Nembutal Elixir—when other dosage forms are not feasible?*

a few inhalations by mouth control cough quickly



The anesthetic-analgesic vapor* from Eskay's Oralator reaches the source of irritation by the quickest route. Inhaled by MOUTH, this vapor is carried directly to the lining of the trachea and larynx, where it acts almost instantaneously to check cough. The patient gets relief in a matter of seconds.

Unlike sedatives and narcotics, the Oralator produces no appreciable systemic effects.

Eskay's Oralator is outstandingly convenient—easy to use anywhere at any time. Your patients will appreciate your prescribing this quick-acting oral inhaler. *Smith, Kline and French Laboratories, Philadelphia*

Eskay's

Oralator

a revolutionary advance in the treatment of cough

*(The active ingredient is 2-amino-6-methylheptane, S.K.F.)

More than Meets the Eye

Sarcoptes scabiei, the burrowing parasites that live under the surface of human skin, never voluntarily desert their host.
Scabies will not clear up spontaneously. The causative mites must be eradicated by appropriate treatment.

Benylate-Breon

(Modified Benzyl Benzoate Lotion)

creamy, white emulsion of 25% Benzyl Benzoate, ready to use, easy to apply, positive in action. Pleasant, agreeable treatment with Benylate does not interfere with work or social duties. . . . Benylate is applied to the moist skin.

Benylate Lotion

BREON

A Benzyl Benzoate Lotion

Supplied:
Bottles of 4 oz., 1 pint, 1 Gallon.

George A. **Breon & Company**

KANSAS CITY, MO.
NEW YORK
ATLANTA
SAN FRANCISCO
SEATTLE

Sample to physicians on request.

sustained local contact

Directly at the site of troublesome vaginal infections

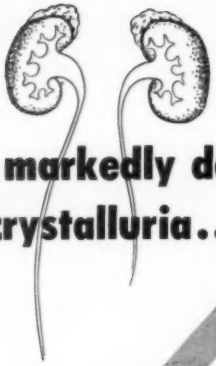
Bristol Penicillin Vaginal Suppositories

In acute vaginitis, and related conditions of the lower female genital tract, caused by, or associated with, penicillin-sensitive organisms, exclusive of the gonococcus; as an adjunct in treatment of vaginal trichomoniasis;

For prophylaxis, pre- and postoperatively in surgery of the uterus and adnexa, or as routine in prepartum preparation.

Bristol Penicillin Vaginal Suppositories contain 100,000 units of calcium penicillin each. They are available for your prescription in boxes of six suppositories.

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK



"...markedly decreased incidence of crystalluria..."[1]

"The use of sulfadiazine and sulfamerazine in mixtures containing equal parts of each drug led to a markedly decreased incidence of crystalluria compared with that observed when either compound was administered singly . . ."[1]

Liquoid Mer-Diazine—a palatable homogenized suspension—presents these two efficient chemotherapeutic agents in equal parts:

SULFAMERAZINE MICROCRYSTALLINE.....1.5 Gm. (22 gr.)
SULFADIAZINE MICROCRYSTALLINE.....1.5 Gm. (22 gr.)

ADVANTAGES OF MER-DIAZINE

- the microcrystalline form assures rapid absorption
- adequate blood level easier to maintain because of slower excretion
- "Liquoid" form makes administration convenient—particularly for children
- penetrates readily into ascitic, pleural and cerebrospinal fluids

Available in 4 fl. oz. and pint bottles. Warning: Sulfadiazine and Sulfamerazine may cause toxic reactions.

1. Flippin, H.F. and Reinhold, J.G.: Ann. Int. Med., 25:433 (Sept.) 1946.

McNEIL LABORATORIES, INC., PHILADELPHIA 32, PA.

Panorama

Voters of Niagara Falls, Ont., have vetoed expansion of city's hospital, authorized enlargement of its cemetery . . . Pending nationalization of British medicine confronts voluntary health insurance with "most serious problem in its history," says British Medical Journal: "The area left to voluntary insurance will be very narrow. Many plans established for the benefit of low-income groups will have to be abandoned" . . . Philadelphia, which claims to be only city X-raying its food handlers, has separated 79 tuberculous persons from their jobs, is keeping an eye on 700 arrested cases.

Physician's aides can make or break the layman's interest in voluntary prepayment, says San Joaquin County (Calif.) Medical Society. It is now training doctors' assistants in public relations . . . Hitchcock Clinic, which donated Hanover Medical Center to Dartmouth Medical School, is contributing $375,000 toward center's expansion . . . All citizens should be compelled to file an annual report on their health, says Dr. Henry H. Kessler, New Jersey rehabilitation specialist. He wants state to keep lifetime health record for each inhabitant . . . Planned Parenthood League collected 80,000 signatures on petition asking Massachusetts legislature to legalize giving of birth control information by doctors . . . Life magazine to auction manuscript of Duke of Windsor's memoirs for benefit of New York's United Hospital Fund.

Chicago now has a special limousine service for getting pregnant women to hospitals and home again . . . Value of chemicals in the human body still fascinates lay writers, who find pre-war appraisal of 98 cents per capita has zoomed to $31 . . . Speakers directory of Ohio State Medical Association

We are proud to announce

Acnomel

a significant advance,

clinical and cosmetic,

in acne therapy

Now, for the first time, you have a preparation which fulfills the two prime requirements for the successful treatment of acne:

1. **Therapeutic excellence.** An exceptional vehicle assures the effectiveness of Acnomel's tried and proved active ingredients—sulfur and resorcinol.
2. **Cosmetic excellence.** Delicately flesh-tinted, Acnomel not only harmonizes so well with the skin as to be virtually invisible, but it also masks unsightly lesions. This, plus its pleasant odor, will make your patients *like* to use Acnomel.

ACNOMEL's therapeutic superiority will please the physician; its cosmetic superiority will please the patient. It is available, on prescription only, in 1½ oz. tubes.

Smith, Kline & French Laboratories, Philadelphia

contains exhaustive list of topics—medical, social, economic, and legislative—for county society meetings, plus names of speakers briefed to handle them.

Common cold is caused by mental depression, says Dr. Douglas G. Campbell, California psychiatrist. He thinks colds are especially common in January because many people have been disappointed by Christmas gifts . . . Stricken with a heart attack, Dr. Ray M. Fouts, Chicago, calmly directed city firemen in administering oxygen to him. He recovered . . . Manuscript Service, Inc., Detroit, claims to offer "first complete editorial service to medical writers." It does research, organizes manuscripts, designs charts and tables, verifies references.

Uncivilized" is Brig. Gen. Wallace Graham's word for the extensive handshaking his prize patient has to do. He'd abolish the hand-pumping marathons President Truman gets into at White House receptions . . . New Veterans Administrator Carl R. Gray Jr., brother of Mayo Foundation's Dr. Howard Gray, hearing plenty of gripes about V.A. delays in paying medical bills. Some Congressmen suggesting V.A. close its thirteen branch offices, let regional offices work directly with Washington. V.A. spending under probe by Commission on Organization of the Executive Branch . . . Main office of World Medical Association to be set up soon in New York . . . Atomic Energy Commission planning a medical and biological research center at University of Rochester.

Physicians in small Ohio town winning plaudits for drawing up weekly schedule of office hours, having it published in local papers. Schedule includes roster of "on call" doctors for evenings, Sundays, and holidays . . . "The most satisfactory type of fiscal arrangement between a radiologist and the average private hospital," says the American College of Radiology, "is a contract under which the radiologist leases the department, including equipment, at a fixed monthly rental" . . . PTA groups in some areas staging "doctors' forums," giving physicians a chance to tell parents about school health problems.

the NEW spasmolytic in liquid form

• Robins' "Donnatal Elixir"* marks an important step forward in spasmolytic therapy. Developed for adults and children alike, this outstanding spasmolytic and sedative now greatly widens the range of its therapeutic usefulness.

• As an elixir, its exceptional palatability . . . its ease of administration and flexibility of dosage . . . together with its prompt, uniform action—all make it the spasmolytic of choice in such pediatric conditions as spastic pyloric stenosis, intestinal colic, diarrhea and enuresis.

• Donnatal's comprehensive spasmolytic effect—with an unusually wide margin of therapeutic safety—results from a synergistic combination of small, fixed amounts of the principal belladonna alkaloids, with phenobarbital. Each 5 cc. (1 teaspoonful) of Donnatal Elixir equals 1 Donnatal tablet in therapeutic effectiveness.

*"Donnatal" is the registered trade mark of A. H. Robins Co.

Ethical Pharmaceuticals of Merit since 1878

A. H. ROBINS COMPANY · RICHMOND 19, VA.

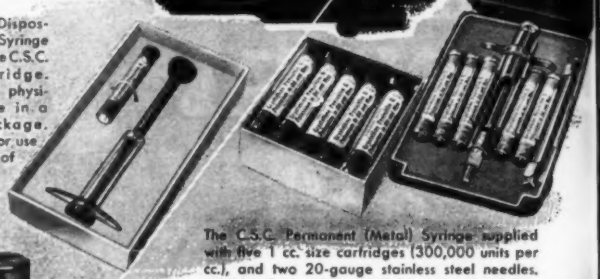
DONNATAL


nd sedative
iform
Robins'
DONNATAL
elixir
OSAGE
fants: ⅓ teaspoonful 2 or 3
mes daily as necessary.
Children: 1 teaspoonful 2 or 3
mes daily as necessary.
dults: 1 or 2 teaspoonfuls,
or 4 times daily.
ORMULA
ach teaspoonful (5 cc.) contains:
yoscyamine Sulfate, 0.1037 mg.
tropine Sulfate, 0.0194 mg.
yoscine Hydrobromide, 0.0065 mg.
henobarbital (¼ gr.), 16.2 mg.
AVAILABLE
pints and gallons.
the Unique Spasmolytic
and Sedative Elixir
elixir another Robins' triumph

PENICILLIN IN OIL AND WAX

CSC

The C.S.C. Disposable (Plastic) Syringe employing the C.S.C. glass cartridge. Reaches the physician sterile in a sealed package. Assembled for use in a matter of seconds.



The C.S.C. Permanent (Metal) Syringe supplied with five 1 cc. size cartridges (300,000 units per cc.), and two 20-gauge stainless steel needles. Additional cartridges available in boxes of five.

Crystalline Penicillin G Potassium in Oil and Wax (300,000 units per cc.) in 10 cc. size and 20 cc. size rubber-stoppered, serum-type vials for multiple injections.

in Every Required Form for Utmost Convenience in Administration

The three dosage forms of C.S.C. Penicillin in Oil and Wax illustrated greatly facilitate the administration of this valuable antibiotic. Penicillin in Oil and Wax-C.S.C.—containing 300,000 units of Crystalline Penicillin G Potassium per cc.—is semi-fluid at room temperature and requires no refrigeration. *A single 1 cc. (300,000 units) injection daily produces assayable blood levels in most patients for 24 hours.* Penicillin in Oil and Wax (C.S.C.) is widely indicated in the management of many infectious diseases due to penicillin sensitive organisms. It is advantageously administered in the home, office, or hospital. These preparations are available through all pharmacies.

C.S.C. Pharmaceuticals

A DIVISION OF
COMMERCIAL SOLVENTS CORPORATION · 17 E. 42nd ST., NEW YORK 17, N.Y.

Red Light's On!

THE "red light" of scientific control is holding up a 24,000-quart tankful of Carnation Evaporated Milk. Not a drop will move on for final processing until the plant chemist has certified that particular "batch" for correct butterfat and total milk-solids content. *Every* Carnation evaporating plant has its own laboratory; and a *central* laboratory regularly double-checks samples from all plants. Thus is assured the *uniformity of composition* that makes every Carnation Milk infant-feeding formula a known and dependable quantity—anywhere and any time.

"ACCEPTED" FACTS

NATION-WIDE surveys indicate that Carnation Milk is more widely used in infant feeding than any other brand of evaporated milk. It is:

HEAT-REFINED—forming fine, soft, flocculent, low-tension curds.

HOMOGENIZED—with butterfat minutely subdivided for easy assimilation.

FORTIFIED—containing pure crystalline vitamin D_3, 400 U.S.P. units per pint.

STANDARDIZED—for uniformity in fat and total solids content.

STERILIZED—after hermetic sealing, insuring bacteria-free safety and markedly diminished allergenic properties.

the Milk EVERY DOCTOR KNOWS

"From Contented Cows"

THE THERAPEUTIC ROLE OF VITAMINS...

. . . is more fundamental than merely to prevent or cure the well-known syndromes of specific deficiency diseases. Restoring carbohydrate and amino acid metabolism to normal is also attributable to the role of vitamins.

Recovery from shock, acute infections, and surgery is accelerated by the administration of two Gelseals 'Theracebrin' (Pan-Vitamins, Therapeutic, Lilly) per day for a week or ten days. Thereafter, one Gelseal 'Theracebrin' daily is sufficient to maintain tissue levels of the essential vitamins.

Gelseals 'Theracebrin' are available in bottles of 30, 100, and 500.

GELSEALS THERACEBRIN

Lilly

ELI LILLY AND COMPANY
INDIANAPOLIS 6, INDIANA, U.S.A.

Speaking Frankly

Prototype

A recent "Panorama" item credits Dr. Paul R. Hawley, former V.A. medical director, with helping to inaugurate the first all-physician American Legion post in the country, at Newark, N.J.

On August 15, 1919, a charter was granted to the Paul Coble Post No. 26 in Indianapolis. Its charter members were all physicians. Eleven are still active legionnaires today.

We extend hearty congratulations to the Newark Post of physician-legionnaires, but must point out that it is not the first of its kind.

W. B. Matthew, M.D.
Indianapolis, Ind.

Execs

The medical profession seems to have given birth to a host of new organizations. Now I hear of one called the Medical Society Executives Conference. What is it?

M.D., Kentucky

The organization was baptized in June 1947. Its charter members are eighty physicians and laymen who serve as executive officers of medical associations. Membership is open to any paid, executive employe of any medical society. Mac F. Cahal, executive secretary and general counsel of the American College of Radiology, heads the group. Its main purpose is to exchange information. By this means it helps executives to execute more efficiently.

Video

For the medical student of the near future, television means the end of droning lectures on anatomy and histology. Its screen will bring every student directly to the dissecting table. Its turret lens will give him a magnified view of each feature being discussed.

The device will open many new pedagogical fields. One example will be its use in the study of highly contagious and infectious diseases, usually isolated during acute stages. Another example will be its use in psychiatric cases where privacy is essential and where a concealed camera can pick up the entire interview. The same thing applies to gynecological and obstetrical clinics.

The invaluable question-and-answer period will then come into its

own. Intercom hookups will make queries and repeat demonstrations a simple matter. The Navy has already inaugurated television as a teaching medium for recruits. For medical students, it should be tops.

James A. Brussel, M.D.
Willard, N.Y.

Scrappers

Florida is the only state, with one exception, that does not grant reciprocity to doctors. I wouldn't be surprised if Florida is violating the constitution in that respect. The state society keeps a powerful lobby at the state capitol to pass laws to keep other doctors from practicing here. The basic science and medical examinations open to out-of-state physicians are so difficult that no doctor out of college five years could pass them without considerable coaching. A former member of the State Board of Medical Examiners said that it was the purpose of the board not to pass any doctor over fifty years old.

I took the basic science examination twice but failed.

More than 325 took the May 1947 basic science examination, but only 162 passed. Doctors who have taken the test call it a most peculiar examination. The only way to pass is to know the subject "from cover to cover" and from every angle.

Doctors here say that tourists are their most profitable patients. Present laws barring other physicians help swell the pocketbooks of the licensed doctors. The lack of competition explains why fees are

Gratifying Relief

. . . through Urogenital Analgesia

The oral administration of 2 Pyridium tablets *t.i.d.*, will promptly relieve distressing urinary symptoms in a large percentage of ambulant patients, thereby permitting them to pursue their normal activities without undue disturbance.

Following oral administration, Pyridium produces a definite analgesic effect on the urogenital mucosa. This action contributes to the prompt and effective relief that is so gratifying to patients suffering from disturbing symptoms such as painful, urgent, and frequent urination, nocturia, and tenesmus.

Therapeutic doses of Pyridium may be administered throughout the course of uncomplicated cystitis, pyelonephritis, prostatitis, and urethritis, without danger of serious side reactions.

Literature on Request

so high. If socialized medicine ever becomes law in the U.S., doctors will have no one but themselves to blame.

John Swanson, M.D.
St. Petersburg, Fla.

I should like to examine the "exposure" by Dr. John Swanson. His charges have appeared also in the St. Petersburg Times.

The "powerful lobby" to which he refers is no one but me. I have been chairman of the legislative committee for the Florida State Medical Association for years. It is a one-man job, with no compensation whatever; and I don't even have a secretary.

In contrast to Doctor Swanson's figures, the official records show that in May 1947 only 279 candidates were examined and 183 passed. In November 1946, 153 doctors were licensed out of the 163 who took the examination. Of these, eighteen were more than 50 years old; one was 74. Within a period of two years 644 practitioners have been licensed.

The countless candidates with whom I have spoken find the examinations difficult but fair. None thinks they should be discontinued. And not one of the 600 doctors in the Greater Miami area would agree that there is no competition for practice. As for the lucrative tourist trade, physicians here agree that only 5 per cent of their income is derived from this source.

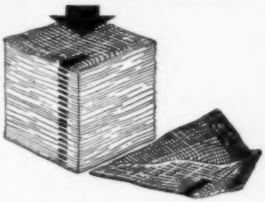
Harold D. Van Schaik, M.D.
Miami Beach, Fla.

sponges show up like this

...because they alone contain this element

Every Curity Radiopaque sponge contains a rectangle of crinoline impregnated with barium. The barium element has these advantages:

- **CAN BE SEEN** clearly with portable or fixed X-ray equipment
- **IS UNMISTAKABLE,** because of shape and pattern, for body structure or artefact
- **IS VISIBLE IN HANDLING.** Black color shows through gauze folds

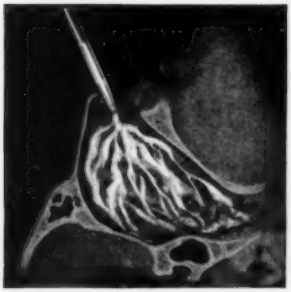


The barium telltale of Curity Radiopaque Sponges and ABD packs is unique. Its shape and pattern make it quickly distinguishable on an X-ray plate from body structure or artefact; its radiopacity makes it easily and quickly identifiable—whether you use fixed or portable X-ray equipment, with or without a Bucky-Potter diaphragm.

The telltale shows through covering folds of gauze (see sketch), and makes every Curity Radiopaque sponge readily identifiable in the operating room without unfolding.

If you use Curity Radiopaque sponges and ABD packs routinely, it is easy to settle the problem of unaccounted-for sponges. For X-ray will determine whether a Radiopaque sponge is in the patient or not. Give Curity Radiopaque sponges a trial and *see for yourself.*

Curity



to protect the sinuses from bacterial invasion

Paredrine-Sulfathiazole Suspension *spreads rapidly in a fine, even film over the turbinates and throughout the meatuses.* This bacteriostatic film helps protect the sinuses from bacterial invasion. The Suspension, therefore — when it is instilled at the first sign of a cold —is particularly useful with patients prone to flare-ups of chronic sinusitis. *Smith, Kline & French Laboratories, Philadelphia.*

Paredrine-Sulfathiazole Suspension

vasoconstriction in minutes...
bacteriostasis for hours

Sidelights

Include Me Out

The American College of Radiology has joined the parade of schools, organizations, and private practitioners who have thrown up their hands at Federal red tape. The ACR, long a leader in post-graduate education, has for some years conducted advanced courses in roentgenology. While admission priority is still extended to physician-veterans, the college now asks to be excused from registering students under the G.I. Bill of Rights.

"The procedure for obtaining tuition refunds is so involved," explains the ACR commission on education, "that application for reimbursement will not be made in the future. The college has not yet succeeded in penetrating the maze of official red tape for the course conducted last year."

Generals Bradley and Hawley, during their administration of the V.A., told their subordinates not to hold up benefits by too rigid an adherence to the commas and semicolons of procedure. But even these battle-hardened veterans seemed unable to vanquish a foe made only of paper. Now that there's talk of much broader Federal subsidies for medical education, it seems high time to seek ways of reducing hidebound protocol. Otherwise we may find some of our best medical schools following the ACR lead.

Prepay Test

Not long ago a physician left a medical meeting feeling pretty much in the air. He had listened to heated arguments over his society's prepayment fee schedule. But he didn't think he'd heard anything convincing.

The fees listed looked low in spots. Yet he knew many a prepay patient would have paid little or nothing without the insurance. He decided to find out for himself just how prepaid medical care was affecting his own practice.

From his files he took 400 records. Half covered one procedure, the other half another. In each category there were 100 enrollees in his prepay plan and 100 non-subscribers.

When he totaled his collections, he found that the difference between the subscriber and non-subscriber groups was less than $25. It

wasn't possible to determine how much the prepay plan had extended his practice, but it was plain the plan hadn't diminished his returns.

Any medical man who suspects prepayment of hurting his practice might have his secretary run a similar check. He's apt to get a pleasant surprise.

Therapeutic Team

Into the senior clinic came a widowed scrub woman with a backache. The student said he'd advise the patient to give up her job, take the winter off. When the instructor asked how a widowed scrub woman could afford to follow such advice, the student retorted: "Sir, I expect to be a doctor, not a social worker."

Actually, there has to be a touch of the social worker in almost every physician today. If we find that before our Rx will be effective, the patient needs help in locating a day nursery, in finding a better job, or in some other respect, we must know the mechanics of securing that help. To let the patient grope his own answers is to supply ammunition to those who complain that, in terms of modern social problems, "private physicians don't know the score."

The alert practitioner learns to know the social resources of his community as he knows the drugs in his hospital formulary. And he uses these resources to help the patient, with the same sense of appropriateness.

There are so many kinds of Eczema . . .

TAR IS THE MASTER REMEDY

Tarbonis is of outstanding value in

Eczema
Psoriasis
Ringworm
Occupational Dermatitis
Folliculitis
Seborrheic Dermatitis
Intertrigo
Pityriasis
Pruritus
Tinea Cruris

In 2¼ oz., 8 oz., 1 lb. and 6 lb. jars.

•

When infection supervenes, SUL-TARBONIS combines the bactericidal properties of sulfathiazole (five per cent) with the virtues of Tarbonis.

. . . AND THERE ARE so many tar preparations! Crude and refined, white and black, and in many different vehicles. In the hands of many leading dermatologists, pediatricians, and general practitioners, Tarbonis is the preferred tar preparation in the management of eczema.

Eczema usually requires intense and prolonged treatment. Tarbonis—alcoholic extract of selected crude tars (5%), lanolin and menthol in a vanishing-type cream — is completely nonirritant. It is safely applied as often as desired, every two hours if indicated, for as long as needed, without producing irritation or furunculosis.

In eczema of the face and hands Tarbonis is especially appreciated since it leaves no trace upon the skin, hence can be applied during business or social activities. Greaseless, nonstaining to skin, linen, and clothing, and nonsoiling; free from all objectionable tarry odor.

THE TARBONIS COMPANY

4300 Euclid Avenue • Cleveland 3, Ohio

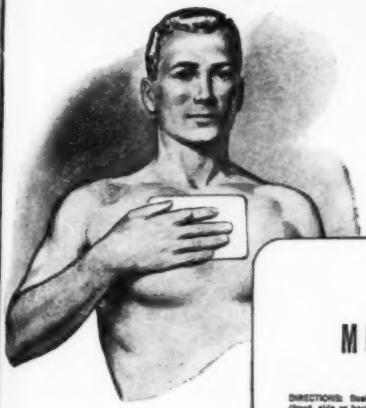
TARBONIS COMPANY, Cleveland 3, Ohio

You may send me a sample of Tarbonis.

Dr_____

Address_____

City, Zone, and State_____



Johnson's

MUSTARD PLASTER

U. S. P.

EXTRA-LARGE SIZE

DIRECTIONS: Soak the plaster in lukewarm water (1 to 2 minutes) and apply to chest (front, side or back). Remove plaster when skin is thoroughly reddened, usually within 5 to 10 minutes.

CAUTION: Do not keep plaster on long enough to blister the skin—never over 15 minutes. If blistering occurs because plaster is left on longer than 15 minutes, apply Johnson's Baby Cream or Petroleum Jelly to soothe the irritated area. When used on children or adults with sensitive skin, place a layer of wet gauze or cloth between plaster and skin.

A Johnson-Johnson PRODUCT

For chest colds

The time-proved mustard poultice in modern, ready-to-use form

The old-fashioned mustard poultice has long been recognized as sound therapy. For example, Blumgarten's "Textbook of Materia Medica, Pharmacology and Therapeutics," 1937, notes that rubefacients or counter-irritants are useful "to relieve pain and tightness in the chest and congestion and inflammation in the lungs."

Whenever this type of treatment is indicated, you will find that Johnson's MUSTARD PLASTERS offer many advantages to your patients. Each plaster comes ready to use. Nothing to prepare. No mess. No fuss. On and off in a few minutes. Heats the spot, stimulates circulation, helps relieve chest colds, bronchitis, sore throat.

Johnson's MUSTARD PLASTERS *are recognized and approved by the United States Pharmacopoeia.*

For a free sample, write to Johnson & Johnson, New Brunswick, New Jersey. This offer is limited to the continental United States.

Johnson's MUSTARD PLASTER

MENOPAUSAL WELL-BEING

Meprane

NEW
ORALLY POTENT
ESTROGEN

Emotional instability, melancholy, spontaneous weeping and insomnia are relieved by Meprane as effectively as hot flushes and other autonomic symptoms, according to a recent clinical report.* Menopausal well-being is now an attainable therapeutic objective. Unpleasant reactions are virtually unknown.

Dosage: In the menopause, initial therapy—1 tablet t.i.d. after meals. maintenance therapy—1 to 2 tablets daily.

Available: Boxes of 30, 100, 500 and 1000 individually wrapped 1 mg. (1/65 gr.) tablets.

* Lin, H.A.C.: Amer. J. Ob. & Gyn. pp. 296-300, Aug. 1942.

REED & CARNRICK

JERSEY CITY 6, NEW JERSEY • TORONTO, ONTARIO, CANADA

ıick relief in every State

ALLY:

"Patient has responded beautifully" — ENGLEWOOD, N. J.

EUREKA, CALIFORNIA — "Rapid service greatly appreciated"

"Most satisfactory results I have ever obtained" — PHILADELPHIA, PENNSYLVANIA

McALLEN, TEXAS — "Complete relief from severe symptoms"

"Benefited almost 100%" — WASHINGTON, D. C.

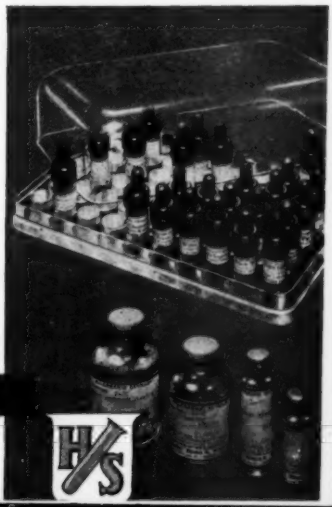
DAVENPORT, IOWA — "Thank you for the rapid service"

"Hay fever sufferer for 27 years, now symptom-free" — PROVIDENCE, RHODE ISLAND

BOSTON, MASS. — "Marked relief from . . . almost intolerable sensitivity to trees"

tly after receipt of orders, Hollister-Stier's ically located laboratories speed personalized s and treatment sets to a rapidly increasing r of physicians for diagnosis and relief of allergy conditions. Hundreds of unsolicited appreciatively praise Hollister-Stier, for their g skill and dispatch—in providing on minimal desired solutions from over 200 pollen and 400 protein allergens, and any type of autog- extract prepared in liquid form (many from als grown in Hollister-Stier greenhouses), and d in convenient vials for immediate use. All ster-Stier allergens are fresh, potent and stable.

e you your copy of our new 48-page booklet, y Reference Reader on Allergy"?

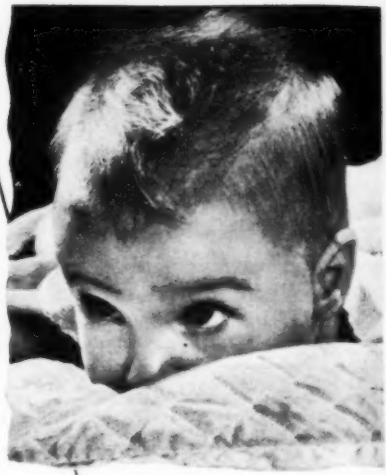


Hollister-Stier

BORATORIES

ded 1921

ISBURG, PA. • SPOKANE, WASH. • LOS ANGELES, CALIF.



Rx

Start him on just a teaspoonful

HOW MANY TIMES HAVE YOU WRITTEN *THAT ONE* . . . and wished mothers would follow your "go easy" advice? For then, babies' introduction to cereal (usually the first solid food after milk) is far easier on all concerned.

When those first teaspoonsful of cereal are *finely strained, good-tasting* Gerber's, it seems that tots get off to a happier start. They appear to favor the flavor and texture of Gerber's all through babyhood. Particularly when mothers remember . . .

Babies like the variety of a rotating schedule of Gerber's Cereal Food, Strained Oatmeal and Barley Cereal. Each is a significant secondary source of protein *and* contains *added iron, calcium* and *yeast*. Result? Better-than-whole-grain values for minerals and B-complex vitamins.

For FREE SAMPLES of Gerber's 3 Cereals—plus professional reference cards, write to Gerber's, Dept. 222-8, Fremont, Mich.

Babies are our business... our only business!

Gerber's

BABY FOODS

Fremont, Mich.—Oakland, Calif.

3 CEREALS • 18 STRAINED FOODS • 13 JUNIOR FOODS

Editorial

Self-Prescription

• When the lay diagnostician puts his stethoscope to medicine's chest, he's likely to report some strange and wonderful ailments. Much of what he finds can, of course, be taken with a grain of salt, but one disorder has appeared often enough on the profession's case history to make the patient sit up and take notice. It might be described as our backwardness in coming forward on matters of public health.

"Doctors as a group have devoted a sizable amount of time and energy to getting behind public health measures," one friendly critic says. "But there is little evidence to indicate that they have often been out in front, inspiring other groups and sharing leadership with them."

The reason for this is not hard to figure out. So much money and so many people have poured into T.b., polio, and other drives that doctors have assumed their leadership might better be exerted where the need for it was greater.

This assumption is understandable but incorrect. Although a number of public health drives are now aimed at specific ailments, a great many diseases continue to be ignored. Such action as has been taken often leaves a good deal to be desired. And in some cases lay health agencies have proved more adept at promoting vested interests than at combating disease.

There is, indeed, room for medical leadership. But where to start?

One idea that's been suggested has promising possibilities. It calls for a general disease-detection center in every major community. Such centers would be sponsored by local medical societies and manned by their members, with plenty of prominent laymen in on the administrative details. They would be geared to turn up almost all the correctable conditions in each local citizen who came to be examined. They would refer people needing treatment to private practitioners.

Chances are that these centers would reap whopping dividends in public health and public relations. They would do much to wrap the leadership mantle securely around the profession's shoulders. And they would help correlate existing drives against individual ailments.

Financing a detection center

should not be too difficult. Minimum fees could be charged, with indigents getting free service. Because such a project would have great popular appeal, lay groups could be rallied to raise whatever extra sums might be needed. Much of the money now spent on detecting single diseases might easily be drawn into a coordinated system of general detection centers.

The main drawback to this bid for health leadership is obvious: Most of us are already burdened with a heavy patient load. In such circumstances, it's hard to get interested in what industrialists would call "new business." Yet one test of a smart industrialist is whether he plans for the lean years during the good years. A chain of physician-sponsored detection centers might well become an important stabilizing influence in medical practice; more than that, it would be a tremendous boon to the public.

In one state where such centers were proposed recently, leaders of the profession balked at setting up a statewide network right away, but they did encourage county medical societies to experiment with such centers locally. The advantages seem so clear that doctors in other areas may well follow that lead.

Public health and private medicine haven't always mixed well. The detection center may be one means to the desired blend.

—H. SHERIDAN BAKETEL, M.D.

"Mind having a look into this thing, old man? There's something staring at me!"

G.P. Academy Binding Local Units Into Strong National Set-Up

Regional groups of family physicians affiliating with fast-growing AAGP

•Family doctors may be Johnny-come-lately's to the business of setting up their own national organization, but they're taking to it like ducks to their favorite swimming hole. A score of scattered G.P. units are being blended into a smooth-functioning national association. The unifying touch is being supplied by the American Academy of General Practice, founded just six months ago.

The success of this drive reflects the appeal of the AAGP platform, which seeks to keep peace in the medical family while vigorously promoting the special causes of the G.P. "What we are after, in the broad sense, is to put general practice on the same level of dignity as the specialties," says Dr. Paul A. Davis of Akron, O., AAGP president. "Family doctors do about 85 per cent of the medicine in this country. They ought to have places where they can hospitalize their patients without a specialty."

But Doctor Davis makes it plain that "we are not a pressure group," as has been intimated by some AMA officers. The AAGP program will be slanted mostly toward keeping practicing G.P.'s up-to-date. Already more than 3,000 family doctors in forty-one states have signed up as AAGP members. New names are being added to the roster at the rate of 200 a week.

To be eligible, a man must have practiced general medicine for at least three years. To maintain his membership, he must complete 150 hours of P.G. work every three years. President Davis hopes to have 70,000 names on AAGP rolls before 1952.

Most local G.P. groups have shown themselves eager to affiliate with the Academy. Minnesota, California, Virginia, Kentucky, Tennessee, Louisiana, and Alabama already have state organizations. Ohio, Indiana, Texas, and Utah expect to join the ranks soon. Similar movements have also started in North Carolina, South Carolina, Georgia, Arkansas, and Kansas.

Affiliation has proved painless, since the purpose of the local group

[*Continued on* 39]

PAY-OFF: The late Dr. Linn Cudworth, family physician from Perry, Mich. (population 879), gets a dressed chicken in payment for a night call. New G.P. organizations hope eventually to boost family doctors' economic status.

usually parallels that of the AAGP. All that's involved is the adoption of the AAGP constitution, with minor variations permitted. The name of the local group then becomes "The American Academy of General Practice of———."Thus, what was formerly the American College of Physicians and Surgeons has become the AAGP of Minnesota.

The AAGP plan is to set up county groups and to tie them into state organizations, with national headquarters directing the drive. Each state will have two delegates to the national convention, to be held in Chicago at the time of the AMA's June meeting. The main business of the meeting will be completing organizational details A permanent national headquarters will then be chosen, with Kansas City, Chicago, and St. Louis the leading contenders.

Meanwhile, the academy is setting its educational wheels in motion. It has established a medical coordinating committee, including (among others) Dr. B. R. Kirklin of the Advisory Board for Medical Specialties, Dr. H. G. Weiskotten of the AMA Council on Medical Education and Hospitals, Father Alphonse M. Schwitalla of the Catholic Hospital Association, and Graham L. Davis, president of the American Hospital Association. This committee will come to grips with three main posers: (1) how to get more courses in general medicine taught by the medical schools: (2) how the academy can help lick the rural physician shortage; (3) how to open more hospital staffs to G.P.'s.

In its campaign to improve G.P. study facilities, the academy plans to stage "P.G. educational days" in regions where no courses are now available. It will also encourage local groups, hospitals, and medical schools to set up more courses slanted for the family physician.

The AAGP is sparked by several men who have been leading lights in the activities of the AMA section on general practice. Dr. Wingate Johnson, former head of the section, is one of the academy's supporters. President Paul A. Davis is also a former head of the AMA section and currently serves on its executive committee. Mac F. Cahal, executive secretary of the American College of Radiology and president of the Medical Society Executives Association, is serving as general counsel and part-time executive secretary to the AAGP during its formative period. The secretary is Dr. Stanley R. Truman, general practitioner of Oakland, Calif. While the academy goes to work at the national level, local organizations are stepping up their activity, too. Among the most successful is the one mentioned in Minnesota.

Another is the American Academy of General Practice of Wayne County, Mich., which has been instrumental in setting up sections on

general practice in a number of Detroit hospitals.

Still another active, local unit is the Society of General Physicians of Cincinnati, which has been conspicuously successful in its post-graduate seminars. These training programs are offered three times a year by the faculty of the University of Cincinnati College of Medicine.

Each seminar confines itself to one field of medicine and meets twice weekly for a total of sixteen hours' instruction. The first of these, devoted to internal medicine, attracted an attendance of 116 G.P.'s. The average at each lecture was ninety-two.

In its relations with other medical organizations, the Cincinnati society has emphasized the cordiality with which its activities have been greeted. As a matter of fact, all the G.P. groups—both local and national—stress that their function is to eliminate frictions between specialists and family physicians. But it's unlikely that they'll be backward about standing up for the G.P.'s rights:

"It should be clearly understood from the outset," says Minnesota's branch of the AAGP, "that the intention is to solidify that group which has, for much too long a time, been content to sit back and permit organized medicine to be run completely by specialist groups. It is only through organization that the general practitioner can begin to express himself." —JOHN BYRNE

Blue Cross Dips Into the Red

Physicians fear that pinch of rising hospital costs may hamper all prepay enrollment

• On the surface, Blue Cross business last month was booming. More than 30 million Americans had been enrolled, and new converts to prepaid hospitalization were signing up at a dizzy rate. But beneath the covers of Blue Cross ledgers, the news was bad.

Many Blue Cross plans were putting sizable dents in the funds they'd saved for a rainy day. During 1947's first half, eighty-eight plans took in a grand total of $111½ million—and paid out $112 million. No doctor had to be told the significance of that deficit; for voluntary hospitalization insurance had long been the bellwether in medicine's fight against state medicine.

Why, in the face of a nation-wide boom, was Blue Cross in trouble? Mounting hospital costs, of course. Back in 1942, when reimbursements to hospitals ate up only 74 per cent of its income, Blue Cross had smooth sailing. But last year Blue Cross had to pay hospitals nearly 90 per cent of its take.

The tribulations of Blue Cross stem in part from the unique qualities of the insurance it provides. Unlike commercial insurance companies, it pays the subscriber in service, not in cash. This robs Blue Cross of the chance to bounce up and down with the economic tides as readily as commercial carriers do.

Under a commercial policy, a patient may get, say $5 a day for a maximum of fourteen days in the hospital. The insurer's maximum liability is thus $70. But since Blue Cross pays in service, there's no cash limit on the amount each patient is entitled to. Rising hospital costs must be paid out of the Blue Cross treasury rather than out of the patient's pocket.

To meet the crisis that confronts them, some Blue Cross men have thought longingly about junking the service principle. One plan has already made the switch to cash indemnification. But most consider the service idea Blue Cross' prize asset, the thing that sets it apart from commercial carriers. So last month Blue Cross was seeking other ways to get out of its dilemma:

Thirty-seven Blue Cross plans had increased their subscriber dues in the past year. About half a dozen

had decided, instead, to trim benefits. In Wisconsin, for example, they had done both: premium rates for individuals had been hiked 20 per cent and allowances for drugs and medications had been cut in half.

In Massachusetts, where the Blue Cross president admitted that past rates had been "based greatly on guesswork" and that "our books were in an awful mess in 1946," the hospital service had to clamp a $9-a-day ceiling on the bills it would meet. The same story was told in other areas.

Blue Cross was having to take in some sails nationally, too. A country-wide community enrollment campaign scheduled for last fall had to be abandoned because of the cost.

Already some physician-backed medical care plans were feeling direct repercussions. While Blue Cross dickered with its member-hospitals over rates, enrollment in some hospitalization plans automatically slowed down. And since medical and hospital plan subscriptions are often sold together, a parallel slow-down hit some doctors' plans.

A disturbing feature of the Blue Cross crisis is what one hospital director calls "the recrimination and criticism" that has been exchanged. For some time, Blue Cross has harbored a number of gripes against the hospitals. For example, most institutions set their private-room rates high enough to cover deficits incurred in providing charity services. Why, ask some Blue Cross officials, should we foot the bill for welfare cases? They should be a city or state responsibility.

Also, they insist, it's unfair to ask Blue Cross to finance a hospital teaching program (by adding the deficit incurred here to private-room rates). For a teaching program, they reason, "is strictly a prestige item" for the individual hospital.

But the hospital people simply don't see eye to eye with Blue Cross men on such points. Says one: "Why should my hospital take a beating for Blue Cross patients? We serve the whole community. We're charging other patients more. If Blue Cross can't meet our new charges, it will simply have to boost its premiums still more."

Adds Hospital Accountant Charles G. Roswell: "The men responsible for the exceptional growth of Blue Cross plans must realize that it is just as important for the voluntary hospital to be financially sound as it is to extend voluntary health insurance to a large segment of the population."

Key to the Blue Cross crisis is the rembursement formula. The three main ways in which Blue Cross can reimburse a hospital are: (a) on the basis of the institution's daily rate for the accommodations provided; (b) on the basis of the actual cost of services rendered; or (c) according to a schedule of rates

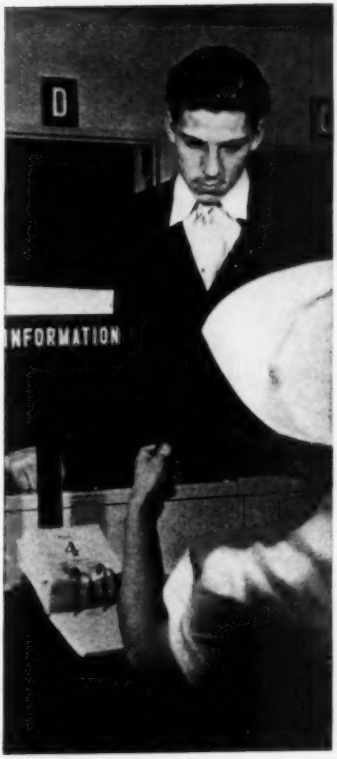
mutually agreed on by the hospital and Blue Cross. The widespread use of method (a), plus rapidly rising *per diem* charges, account for Blue Cross' present difficulties.

Some hospitals are willing to rewrite contracts so that reimbursement will be on an actual cost basis. But unstandardized (and sometimes peculiar) methods of hospital accounting make Blue Cross leery of this solution.

As for method (c), to put it fully in effect would require arbitration with each of the 3,800 voluntary hospitals with which Blue Cross has agreements. The health insurance agency sees no short-range solution there.

An ordinary business man would probably suggest the cash indemnity solution as the only practical one. But from the viewpoint of both hospital and Blue Cross men, reimbursement by service has always been considered more "ethical" than cash indemnity. Prepay leaders feel that the service principle is responsible for much of its civic support and popular appeal.

But Blue Cross will have to resist increasing pressure from those favoring cash indemnity. At last year's session of the American Hospital Association, an executive of New York's United Hospital Fund concluded that "a retreat from the service principle may be necessary." And a hospital administrator said, "It is unreasonable for Blue Cross to expect hospitals to provide a hedge against inflation. The only real solution is indemnity contracts."



BILL BLUE CROSS! Soaring hospital costs don't hit subscribers as heavily as they hit the insuring agency.

One development that would help get Blue Cross away from the shoals is a nationally uniform poli-

[*Continued on* 190]

LANDFARER

When a confirmed landlubber harbors a frustrated love for things nautical, the result can easily be schizophrenia. In Henry J. Sealey's case, the result has been far happier, as witness the rakish land cruiser shown on these pages. Each vacation-time the Dumont, N.J., surgeon boards this pavement-bound luxury liner, casts off his mooring lines, and plots a course to the farthest reaches of his macadam sea.

Doctor Sealey's craft is nothing if not landworthy. Into its thirty-three steel-and-aluminum feet are packed enough creature comforts to put to shame even J. P. Morgan's former yacht Corsair. It has a complete air-conditioning system, automatic refrigeration, a 3,000-watt generating plant, hot-and-cold running water, and an interior telephone system.

And talk about parlor, bedroom, and bath: The Sealey road clipper sports a lounge complete with easy chairs and a glassed-in observation bridge above. It has bunking space for eight that even the latest Pullman can't match. There's a tile-lined bathroom complete with stall shower. And the galley is equipped with both electricity and gas.

If guests should tire of this en-

vironment, the doctor can always whisk them away in the ship's tender. The latter is a three-wheel motorcycle that seats four. While the mother ship is under way, the tender is housed in a compartment aft.

Doctor Sealey has always been a man who takes his vacations seriously. Just before travel was declared an unpatriotic misdemeanor in 1942, he indulged in a conventional, cross country auto tour and found it sadly lacking in the conveniences. For some time thereafter, he mulled over the idea of something a little bit better. Detroit hadn't produced anything that met his ideals of comfortable touring, so now he asked himself exactly what he wanted, then persuaded a friend to build the seven-ton, 125-horsepower answer. Anyone who has the Sealey ingenuity and $20,000 ought to be able to follow suit. A high point in the doctor's cruising was a recent trip to Popocatepetl and Mexico City where he was visited by Ambassador Thurston, whose interest was typical of that displayed wherever the cruiser goes.

SEALEY CLIPPER has caused natives to gawk from Mexico to the Canadian Rockies. Newsreels and Sunday supplements have featured the doctor's sumptuous land yacht. (Right) A passenger goes topside where the skipper keeps a weather eye on the horizon ahead.

VACATIONIST

Rubberneck guides in Washington, D.C., make a point of showing sightseers the Japanese cherry blossoms, the piano the President played to Lauren Bacall, and the room where Howard Hughes investigated a Congressional committee. They might well add to their repertory the office of a District of Columbia physician who spent a two-week hunting and fishing trip performing 740 free operations.

Six months later this same ALR specialist took another fortnight off and operated on 800 children. What's more, Dr. William A. Morgan did not lose a single patient. And to the colorful Caribbean island of Santo Domingo, where he spent these busman's holidays, he brought a new deal in nose and throat surgery.

It all started when Doctor Morgan's addiction to rod, reel, and rifle was exposed to a West Indies travel folder. A refugee from the capital's marble montony, he found the Dominican Republic a nature-lover's nirvana: untouched stretches of jungle, bright-hued birds, gamey fish. But he also found other things: children wilting from nose and throat ailments because there were not enough doctors.

He learned that President Trujillo would welcome help in improving the island's health. That was all he needed. His first step was a local orphanage where he set up an impromptu operating room. Soon word got around about this unusual visitor from the states. With beds overflowing into corri-

dors, Doctor Morgan then had to commandeer space in hotels and armories. In one day, working under the most primitive conditions, he performed seventy-two tonsil and adenoid operations.

Later that first week, after operating all day in Santiago, Doctor Morgan returned to Ciudad Trujillo only to learn that he had left a bad case of worried mother back in Santiago. A pilot during World War I, he found a light plane and made a hundred-mile flight in driving rain to hold the lady's hand.

Even at plane pace, he only brushed the surface of the island's needs. So, half a year later, he returned to Santo Domingo and went through another medical marathon. After 800 operations he finally collapsed—not from fatigue, but from the doses of ether he had inhaled.

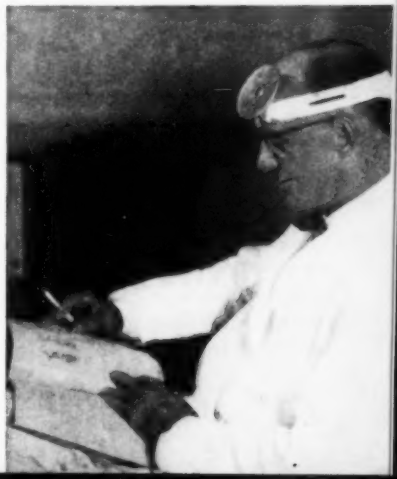
Today this tall, bespectacled 57-year-old wears the "Order of Merit Juan Pablo Duarte," the highest honor conferred by the Dominican Republic. This was President Trujillo's thank-you for Doctor Morgan's scalpel skill. It's the doctor's proudest possession.

Meanwhile, Doctor Morgan has faced up to the fact that the medical salvation of the Republic is no one-man job. Why not encourage other American doctors to take their vacations in this tropic playground? The project was proposed to the Medical College of Virginia, from which he had graduated in 1917. The school is now tinkering with plans for an annual pilgrimage of alumni to Santo Domingo.

Doctor Morgan makes light of his contribution to the health of the tropic isle. "Lots of the native doctors have done much more for the poor people than I have," he says. "Many have never collected a cent for surgery they've performed. They feel they owe it to their people."

Even in such company, the American is looked on as a phenomenon. When the Trujillo decoration was hitched onto his lapel, 400 native physicians assembled to wish him well. As Doctor Morgan was leaving, several of them said: "Be seeing you next vacation-time." Chances are, they will.

AT EASE after performing 1,540 free operations during two Dominican holidays: Dr. William A. Morgan. On the opposite page is the modern hospital Santo Domingo named for him by way of thanks.



SNOWBIRD

Arthur Perkins, an Ogden, Utah, physician who retired from practice some years back, has found himself a new specialty in the medical implications of an overshot Christiania or a botched Telemark.

SKI TEAM consisting of Dr. Arthur Perkins and wife is a familiar sight on Utah slopes. Family group often breaks up on short notice when the doctor hustles his patrol to aid some stricken skier.

He is medical director of the National Ski Patrol System, an organization of first-aiders on hickories that has put the Saint Bernard back in the doghouse.

Ten years ago, Doctor Perkins didn't know a stem turn from a twisted twig. When some friends suggested an afternoon on the boards, he almost had to be dragged along. But the first taste sold him on the art. By the time he'd gotten past the pratfall stage, he'd seen plenty of skiing's occupational hazards, the bruise and the break.

In nearby Snow Basin, where they ski from November to mid-April, that meant a goodly number of mishaps every season. So in 1940 Arthur Perkins organized the Snow Basin Ski Patrol, helped train its members to whip up a mountainside, splint a fractured leg, and toboggan the patient to shelter. In seven years the Perkins team averaged 100 assists per season.

Last year, when most of the country's top skiers were in the Perkins bailiwick for the national races, the doctor's patrol played a leading part in arranging the program. By way of preparing for an avalanche of casualties, Doctor Perkins alerted three ambulances and a stand-by crew of fifty. But the champions threw little work their way. The doctor managed to conceal his disappointment when the only skier to come a cropper during the meet got up unaided and walked nonchalantly away.

Most of the patrol's service is given to beginners, who account for three-quarters of all the accidents. As a late-in-life beginner who escaped unscathed, Doctor Perkins can offer sound tips for avoiding spills. His team helps spread the gospel not only on skiing technique but also on how to behave in various snow conditions.

When the 52-year-old doctor was tapped for the top spot on the National Ski Patrol's medical committee, he plunged into a novel statistical study that's still going on. It indicates, for example, that (a) for every 250 skiers out on any given day, one will be injured; (b) half the mishaps occur on relatively flat terrain; (c) a contributing factor is the all-day pass for ski lifts, which encourages folks to take "just one more run" when they're really too tired to do it safely.

The Perkins Rx is a pay-as-you-go plan for ski lifts, calculated to make overzealous skiers sit that last one out. Yet the doctor himself is the first to admit that no form of prevention, economic or otherwise, can be depended upon to control fully the disciples of the schuss.

Medical Crisis in Britain

Bevan divides the doctors: BMA would like to divide Bevan—into small pieces

● A cunning man, Aneurin Bevan, English Minister of Health. He has learned the maxim of the Roman emperors: divide and rule. His long delayed answer to the medical profession of Great Britain, which has been arguing with his Ministry for months over the National Health Service Act to come into operation next July, makes it plain that he hopes to get his way, not by a flourish of swords but by a driving of wedges.

To the consultants and specialists he is conciliatory. He has made them the great concession that in the state hospitals a limited number of beds will be available for them to treat patients without restriction on fees charged. He has agreed also that nursing homes, where these consultants and specialists have their most expensive patients, shall not be taken over by the state, as the hospitals have been.

But to the 21,000 general practitioners his milk of human kindness has turned sour. On all the main points they have urged before him —that there shall be no "directing" doctors where to practice, that the custom of buying and selling practices shall not be abolished, that remuneration of physicians in the national service shall be by capitation fee and not by salary—on all these points his answer has been a Molotoffian "No!"

Appeal to Youth

On the other hand, the financial terms he offers doctors are generous—at least they are likely to be considered generous by young doctors, although to well-established men they will mean financial loss. And here we have another wedge driven: Many young doctors will want to go into a secure and well-paid service; the older practitioners will want to stay out.

The objection of the medical profession to receiving a salary stems from several things. Take, for example, the old tradition of fee for service. It meant a great struggle

---

**Harry Cooper, author of this report from England, is* MEDICAL ECONOMICS' *London correspondent.*

thirty-five years ago when national health insurance came in, to reconcile doctors to capitation fees, whereby a doctor accepted on his list so many insured persons for whose medical care he was liable and received some two or three dollars a year for each of them. But capitation has worked well. In practice it has left the relations of doctor and patient very much as they were. There has been no intervention by a third party. And the only obligation of the doctor has been to his patient.

The Bevan Plan

A different situation arises with a salary paid by the state. Mr. Bevan's idea is to offer every doctor who accepts a reasonable (but as yet unspecified) number of patients a basic salary of $1,200, and to add to this a capitation fee of about $3 for each patient. Thus, assuming 45 million people in Great Britain go on doctors' lists, a fund adequate to meet the anuual charges would be created by the Government and would be distributed largely among doctors, in accordance with their undertakings. If, for example, a doctor had a list of 1,000 public patients he would receive the basic salary of $1,200, plus $3,000 capitation, making a total of $4,200. If his list extended to 2,000 public patients he would again receive $1,200, plus $6,000, or $7,200 altogether. And if he took 4,000 patients—which he could do only with the help of assistants—his pay would total $13,200, less the salaries of the assistants.

All Is Not Gold

These figures may well dazzle the eyes of some young doctors, just as some older men facing retirement may be attracted by the offer of a share in a fund of $264 million, which the Government has set aside as a solatium for the loss doctors have sustained through inability to sell their practices. But the leaders of the profession and most general practitioners, represented by the British Medical Association, regard these arrangements with grave suspicion. They see in them the beginnings of a whole-time state salaried service, in which the doctor would have a divided obligation on the one hand to the patient and on the other to the state as paymaster and controller. They see the young practitioner drawn to the system because, instead of having to borrow money to buy a practice, with the debt hanging round his neck for years, he has the prospect of entering upon a practice ready-made. In return he may not greatly object to being directed to the industrial areas of Lancashire or Yorkshire or to Mr. Bevan's own South Wales, instead of to salubrious overdoctored places like Bournemouth or Torquay.

Meanwhile, the fight is on. The BMA talks about expropriation of

practices, injustice, and plunging the profession into uncertainty over its future. There is a particularly sharp division of opinion between the profession and the Minister on the interpretation of the sections of the act which relate to prohibition of the sale of practices and compensation for loss of right to sell. The profession has invoked a celebrated King's Counsel and another lawyer who say that these sections are contradictory or that there is such ambiguity as makes it difficult or dangerous for doctors in partnership to determine whether to enter the service. The Minister says he has legal advice to the contrary. The issue may have to be fought out in the courts.

As for the future: By the beginning of February 1948, every doctor in the country will have been asked by the BMA whether he is prepared or not to enter the service. In last year's poll conducted by the BMA, only 37 per cent of the physicians indicated a willingness to even discuss further the government's proposals. The majority of those favoring further discussions were those practitioners who had been in practice for less than seven years. Physicians who had been in practice for over fifteen years were overwhelmingly opposed to the

"Before I ask you to marry me, Eloise, how do you stack up on the Wassermann test?"

Government-proposed program.

If the new poll of general practitioners and associated groups shows a majority against accepting service, and if this majority includes something like 63 per cent of all general practitioners, as apart from any others, the association will be likely to advise members of the profession not to enter into any contract under the new service.

This will not mean a "doctors' strike." It will mean that general practitioners will continue in their practices but without entering into contracts with the "local executive councils," the new bodies with which the "state" doctors would ordinarily be under contract. It means also that consultants and specialists will go on with their hospital work but will not enter into contracts with regional hospital boards. Patients will be attended as usual, but the act will be a dead letter.

Opposing Camps

One possibility is that there may be a slight majority of general practitioners against acceptance of service and a majority of consultants and specialists in favor. In that event, there may be a grudging and gradual acquiescence in a state service, with a considerable number remaining out and with no satisfaction to anybody.

The battle between the Minister and the profession is really a battle between expediency and principle. The Minister has such rich gifts to dangle as secure remuneration and an end to the old competition to get a footing which exhausts many a young practitioner when he should be doing his best work. On the other hand, the profession hews to the principle that the new service is in conflict with its traditions and standards. To quote a manifesto issued by the BMA:

"The medical profession, while never willing to withdraw its services from the public, is fully entitled to say that the state service offered is, in its considered view, opposed to the best interests of the public and the profession. There remains one final question and one central issue: Does the service as described by the Minister conflict with the traditions and standards of a great profession? There is only one answer the association can give: It does so conflict."

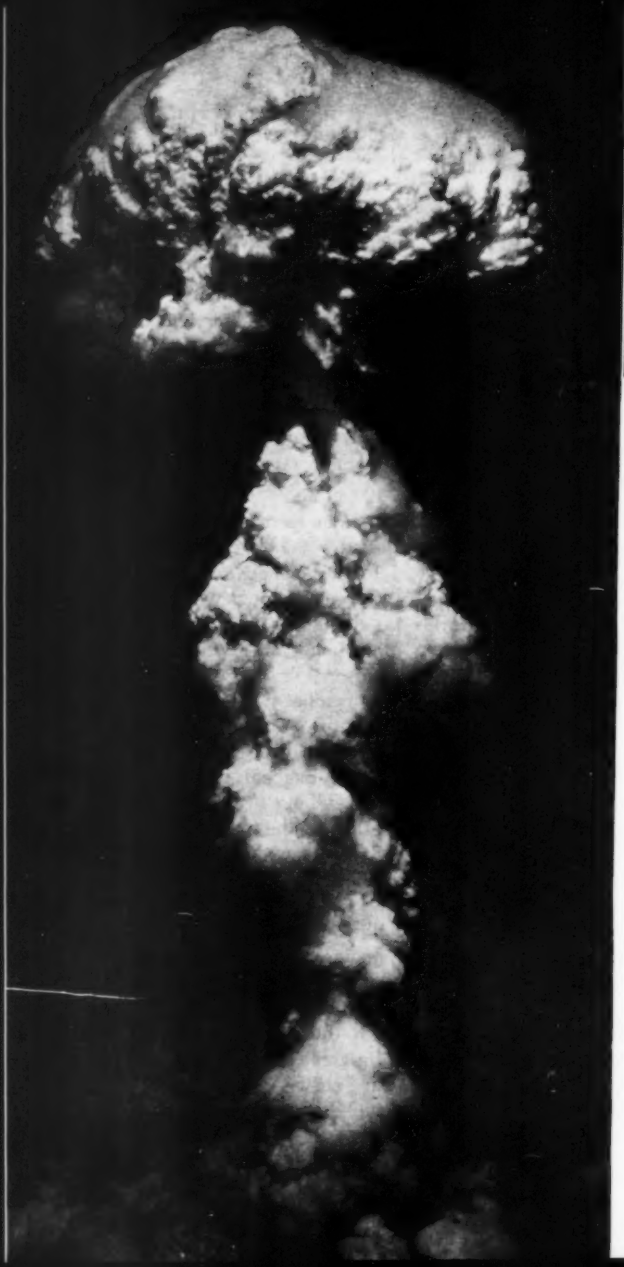
—HARRY COOPER

* HANDITIP *

Hushed Phone

Absolute privacy for your telephone conversations is assured with a new-model silencer that snaps onto the mouthpiece of your phone. More compact and lighter than earlier types, it filters your words through to the caller while making your voice inaudible to a patient at your elbow.

* * *



P
L

H
co
P
of
in
gi
n

•
ch
tu
a
o
y

XUM

Plans for Civilian Medical Care Lag in Face of Atom War

Here is the grim fact that confronts U.S. medicine today: Preparation for the huge load of civilian casualties expected in World War III has been given little attention, almost no direction since V-E Day.

• It is just after midnight on a chill February night in 1954. You turn sleepily out of your driveway and head for the hospital. You snap on your radio. In fifteen minutes you'll be in the operating room.

Then it happens: The announcer's voice comes in staccato and shrill. The first words you hear are "flaming rubble... radioactive mist." They jolt you wide awake. The voice rushes on, more intelligible now: "Health commissioner urges . . . evacuate city within three hours . . ."

Is it a disaster—or worse? The feverish voice dispels your last doubts: "San Francisco: hit from the air three minutes after New York. No details . . . Washington: explosion three miles north of the White House. The President, miraculously unharmed, announces . . ."

In the careening car, wild

TOMORROW'S TARGETS: the civilian inhabitants of our cities. Peacetime disaster units in U.S. have worked wonders when handling as many as 5,000 casualties. But a single bomb dropped on Nagasaki caused 300,000 casualties. Up against such a cataclysm here and without advance planning, physicians would find themselves helpless.

thought fragments churn through your mind: "Three cities . . . a million casualties . . . they've got to be brought out—we can't go in . . . we knew civilians would get it first . . . why didn't we get ready? . . . how can I help?"

For many a U.S. physician, World War III might start with just that feeling of helplessness. Major cities might be reduced to radioactive heaps—with surviving medical men capable of only scattered and sporadic assistance, victims of

the lack of preparation for just such a cataclysm.

That prospect is one most people would rather not think about. But last month, medicine's leaders had to face it: Little was being done in the way of planning for civilian medical care in the next war. Yet civilians would be the main target. Said Dr. Edward L. Bortz, AMA president: "Not one community is prepared today. We have no plan."

Deciding all the intricate details of a pattern for civilian care may take two years, say responsible medical sources. Then, after we know what we want, says AMA Secretary George F. Lull, former Deputy Surgeon General of the Army, it will take still another year or two to whip our medical facilities into shape.

That could mean four years between us and medical preparedness.

The immediate danger is that the public will be lulled into a false sense of security. The Army and Navy, for example, are both re-

[*Continued on* 58]

cruiting reserve medical teams. Publicity given such projects is comforting—but misleading. Forming military units before we know civilian population needs simply underlines our failure to contrive a comprehensive plan.

Shots in the Dark

Some other samples of current developments that have not been integrated:

¶ A special five-man board recently reported to Secretary of Defense James V. Forrestal. To protect our civilian population in atomic and biological warfare, the board said, we must disperse. That means relocation of physicians and medical services. But no one has even begun to come to grips with that massive problem.

¶ The Army Medical Corps is sponsoring courses in atomic medicine at a handful of medical schools. None has been opened to doctors in private practice.

Several other organizations, with a view to the next war, are researching nutritional problems.

Blissful Ignorance

Of our lack of overall medical planning, the public knows little. People tend to assume that medical personnel and supplies will somehow be available. They may even think the disaster units that can relieve a Texas City holocaust could cope with an atomic war. They may believe the tedious jobs of mapping out evacuation systems and of blueprinting casualty care have been done. Yet today, nearly three years after V-E day, we are barely getting started.

There are signs now that plans *will* be blueprinted. Physicians who have been restive are keeping an eye on a new Government agency, the National Security Resources Board. It is charged with coordinating all mobilization of manpower and materials. But medical men will want the design to take shape faster than it gives promise of doing.

The First Step

The board, headed by ex-transportation executive Arthur M. Hill, was established last November. It has just begun to function. About medical care of civilians, Mr. Hill told this magazine: "We are conscious of the problem. We are trying to get someone to work it out."

Medical planning must, of course, be fitted into the thinking on other matters. But the NSRB's mission is such that medical care of civilians could easily get only a minor look-in. The board will naturally be more concerned with production and stockpiling of basic materials.

Organized medicine is eager to help. Last year the AMA trustees created a Council on National Emergency Medical Service. Its primary functions: (a) to spotlight the present lack of planning for medical care of civilians; (b) to see

[*Continued on* 174]

KEY to future planning for civilian care in wartime will be Arthur M. Hill (top left), who heads the new National Security Resources Board and is still in the process of putting his organization together. Meanwhile, Surgeons General Raymond W. Bliss of the Army, Clifford A. Swanson of the Navy, and Thomas Parran of the PHS are laying war plans for their own services; they have little time to think about the medical care of civilians.

Top Agencies in Medical and Hospital Prepayment Plan Merger

Hawley will head Blue Cross, Associated Medical Care Plans, as two prepare to amalgamate

● On the horizon last month was a revamping of voluntary health insurance plans that would warm the cockles of many a medical heart. Some physicians had long wanted a closer-knit leadership for medical and hospital plans. Others had fretted over enrollment lost because of plan variation from state to state. Now these men were seeing hopeful signs of the prepay progress they had sought.

Next month a broad blueprint will be drawn for

¶ Merging the Blue Cross Commission and Associated Medical Care Plans, coordinating agencies in the hospital and medical fields.

¶ Appointing prominent laymen to the policy-making board of the new organization.

¶ Setting up a separate national insurance company to enroll employes of business firms that operate in more than one state.

Key figure in administering this scheme will be Maj. Gen. Paul R. Hawley. The former medical director of the Veterans Administration is to become chief executive of both the Blue Cross Commission and AMCP. He'll take over after the two meet in Los Angeles late next month to talk over the details of their merger. Later he'll head the unified organization that results.

Most medical and hospital leaders are tickled pink at the idea of having hard-driving Paul Hawley on the job. "With Hawley in the driver's seat," says one, "things should really begin to move."

None of the three steps now being worked out is a new idea. The national insurance company has been talked about since 1939. Main obstacle has been the estimated $500,000 it will need to get started. But Blue Cross plans now have about $60 million in reserves, medical plans approximately $12 million. They can afford to put up the money even with some uncertainty about getting it back.

AMCP and Blue Cross both think such a company will send enrollment skyrocketing. Through it, an employer will, in effect, get the same benefits at the same premium for each employe. State-to-state dif-

ferences in plans can be eliminated. These things may well open the door to elusive national accounts.

Merger of the Blue Cross Commission and AMCP has been in the air since AMCP was born two years ago. Fears among medical men that medical care plans would be swallowed up in a joint organization have largely disappeared. Still, some delegates to the AMA's interim session last month wondered about Blue Cross' providing 80 per cent of the Hawley paycheck. A few feared the hospital plans might call the tune. On the other hand, a small group of hospital plan administrators openly labelled the deal a sell-out. They didn't like the idea of having a physician as their top executive.

Minority criticism of the scheme is inevitable, say prepay leaders. They are more impressed that AMA officers are supporting the new move as are leaders of the American Hospital Association.

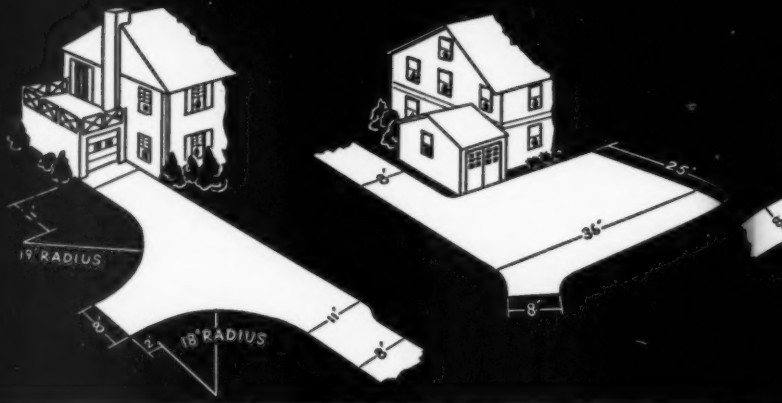
Both associations concluded some time ago that the public must be given more of a voice in prepay policy matters. As eminent laymen help direct the plans, it is predicted, their business know-how and personal prestige will prove invaluable. More than that, it is said, prepayment will come closer to being the public trust it should be.

That 1948 will see the unified organization and the new insurance company in operation is not certain. One insider describes the outlook this way: "We've checked with many hospital and medical plans. All of them have said they'll go along. They'll support the new corporation; they'll help finance the insurance company. It may take most of this year to put the ideas across, but the odds look good."

Not so good, meanwhile, are the odds for detractors of voluntary health insurance. They have consistently criticized the prepay plans for "expensive duplication" of leadership, for "leaving the public out" of policy-framing. Now, it appears, the points may be broken off two of their favorite needles.

—EDMUND R. BECKWITH JR.

TROUBLESHOOTER Paul R. Hawley, after breathing new life into the V.A., now tackles the prepay plans.



FRONT ENTRANCE garage can use a driveway with turn-around to eliminate backing into traffic.

REAR ENTRANCE garage requires plenty of maneuvering space. Dimensions listed are exact ones to use

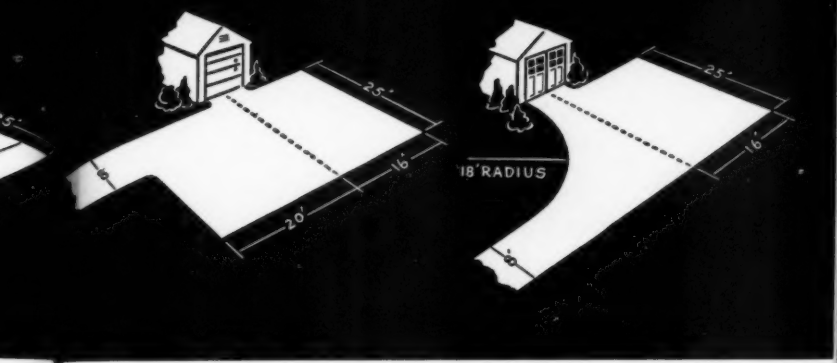
Subject:

Driveways

● Time was when the physician's driveway consisted of a pair of ruts leading to the stable door. These pages show how the old approach has taken on the New Look. Nowadays your driveway has to serve as a parking space for patients, a decorative part of the landscape, an emergency exit for your own car, or any combination of the three. Combining these functions without creating an obstacle course takes a bit of doing.

If you're laying out a one-car driveway, make it at least 8 feet wide on the straightaways, 11 feet wide on the curves. For a two-car approach, you'll find that 16 feet is the safest width. For peace of

SLOPING DRIVE won't cause bent exhaust pipe if grade is under 15%

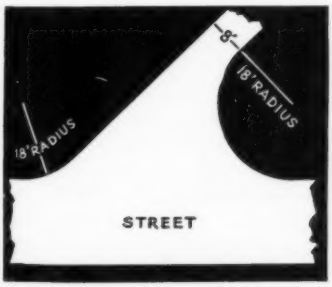


SIDE ENTRANCE garages need large aprons too, but these can double also as parking space for callers. Sketch at right shows how less concrete and more lawn result if you provide for a wide turn directly into garage.

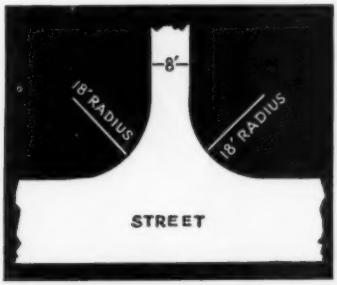
mind during winter months, be sure to arrange for at least 15 level feet directly in front of your garage door.

If a fence or stone wall runs near the edge of your driveway, think about installing side curbs. They'll help to keep visitors' cars in the straight and narrow with nary a scraped fender.

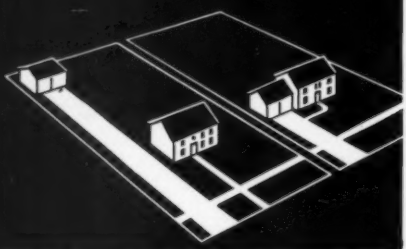
For additional driveway ideas, turn the page.



DIAGONAL DRIVE is easier to enter if inside corner is gently rounded.

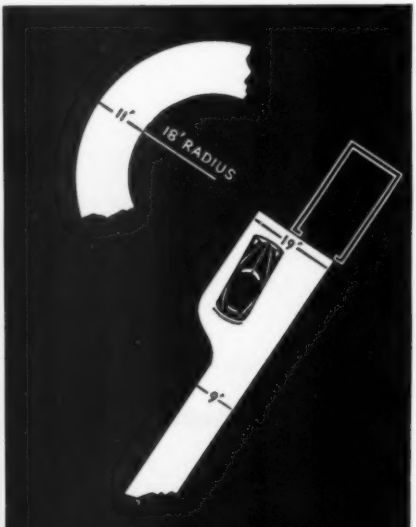


RIGHT-ANGLE DRIVE on a narrow street requires a flaring entrance.



IRKSOME AND EXPENSIVE is the full-length drive at left. Long backing required will prove a continual source of annoyance. Of course, even a short drive should leave enough room for off-the-street parking.

HIDDEN DRIVE is apt to mean trouble, whether you come out backwards or frontwards. Don't let high bushes and overhanging foliage block your view of passing pedestrians and of traffic on the street.



SHARPEST TURN in any driveway should be designed with an outside radius of at least 29 feet, an inside radius of at least 18 feet. Still gentler curves help to protect your lawn from becoming tire-marked.

EXTRA SPACE can accommodate a second car while keeping the driveway clear should you have to answer a rush call. This space will also be extremely useful if you enlarge your single garage to a double.

Tues for Handling Interest Deductions

ost of the interest you pay unts as a tax deduction — t beware the pitfalls

Don't feel too badly when the ne comes to pay the interest on t mortgage of yours. Indirectly, ncle Sam foots about one-third e bill in the form of a reduced ederal income tax.

Interest deductions comprise one tegory that the tax collector is etty liberal about. It makes no fference whether the interest you y is connected with your profes-n, your business activities, or ur personal life; the law permits st of it as deduction.

You can, for example, deduct e interest you pay during any ven year on

¶ Amounts borrowed for pur-ases of professional equipment.

¶ Loans for personal needs.

¶ Brokers' accounts.

¶ Notes of others signed by you co-maker.

¶ Deficiencies in Federal and te taxes.

But you can't take a deduction r the interest paid by you on meone else's personal obligation for which you have no liability. If, for instance, your wife is listed as the owner of your home and is directly liable on the bond and mortgage, you can't deduct mortgage interest paid by you. If you own the house, however, you *can* deduct the mortgage interest you pay, even though you are not liable on the bond and mortgage.

What if you borrow money to buy securities? If those securities are fully tax-exempt, the interest on that loan can't be checked off taxable income. But buy securities that are taxable and you have the tax collector's blessings in making the deduction.

Sometimes a deduction for interest expense is disallowed because you can't prove the payment was actually for interest. Suppose you buy a new car for $2,000 and finance the purchase by signing a contract calling for a repayment of $2,100. Unless the contract states specifically that the extra $100 is interest, you may be unable to claim it as a deduction.

The same applies to most installment buying. To make the interest deduction allowable, your contract with the seller (or your actual payments) must show segregation of

the interest from the principal. Deferred payment deals are variously set up as personal loans, conditional sales, bailment leases, chattel mortgages, and the like. Have the interest element in any of these clearly labeled as such.

The *when* of interest deductions can be just as important as the *how*. It's often possible to save on your taxes by paying interest in advance:

Assume that you are liable on a $10,000 mortgage, that the annual interest is $400, and that the mortgage is to be paid off in a lump sum in 1957. You had an unusually good year in 1947, netting $12,000. So in December you mailed out your check for $2,000, earmarked "five years' interest in advance."

Result? Your income tax bill for 1947 will be $722 lower than it would otherwise be. True, you'll lose much of that gain during the next five years, since you'll then have no mortgage interest to claim as a deduction. But even if tax rates don't change, you'll be $76 ahead in the long run. And since tax rates will probably drop, the saving is likely to be much more pronounced. A flat 10 per cent cut, effective in 1948, would make your gain on this prepayment maneuver $140. —ALFRED J. CRONIN

"Don't be so ornery, Paw—go ahead and breathe a coupla times for him."

Financial Plight of World Medical Association Eased by Subsidy

$50,000-a-year gift from U.S. manufacturers will help WMA to get off the ground

• Until last September, the new World Medical Association had been virtually poverty stricken. Delegates to its annual meeting in Paris arrived with gloomy predictions that income from dues would never top $20,000—nowhere near enough to meet basic operating costs. But the fledgling association took a new lease on life when a dozen-odd U.S. industrialists put up $50,000 and promised to match that subsidy each year for the next four, if necessary.

The WMA's benefactors, most of them pharmaceutical manufacturers, had their interest aroused in the project by officers of the American Medical Association. Four of the contributors will serve on the U.S. Committee that will supervise the gift. They are: S. Dewitt Clough of Abbott Laboratories; A. L. Rose of Mead Johnson & Co.; Robert Lincoln McNeil of McNeil Laboratories, Inc.; and Elmer H. Bobst of the William R. Warner Co., Inc. Joining them on the committee will be Dr. Roscoe L. Sensenich, AMA president-elect, and the three-man executive committee of the AMA Board of Trustees. The funds they administer will be spent largely on rent, travel, salaries of the WMA staff, and publication costs.

Take Back Your Gold

Because of the WMA's earlier red-ink prospects, most delegates jumped at the subsidy offer. But the representatives from France objected vigorously. They voiced fears that American money would mean American control. And why should a U.S. committee supervise the gift?

But the WMA's general assembly overrode French protests after Dr. Louis H. Bauer, U.S. delegate, had explained: "The subsidy was offered before the WMA had been formally organized, before its aims had been firmly established. Naturally, the people who put up the money wanted to protect themselves." The assembly then gave its nod to the arrangement, although emphasizing that "nothing in these resolutions shall diminish the au-

thority of the general assembly."

To the French it may have appeared that the tables had turned. Before the war, world medicine had tried to organize through the Association Professionelle Internationale des Medecins. Largely French controlled, it had gone "so far to the left" that the AMA had bowed out. Later the APIM had become a war casualty. When the French tried to revive it, British and American physicians voted instead for a brand-new association.

Basic Objectives

The basic philosophy of the WMA was roughened out at London in the fall of 1946. At that time the association was committed tentatively to six aims:

1. To promote closer ties among the doctors of the world.
2. To protect the honor and rights of the medical profession.
3. To study professional problems in various countries.
4. To set up an exchange for technical information.
5. To formulate medicine's viewpoint for the World Health Organization and other official bodies.
6. To assist the world's people to attain the highest possible level of health.

At their most recent meeting, WMA delegates added a seventh aim: "To promote world peace." The addition had been suggested by the unit's American subsidizers, who hoped medicine could provide new channels for cooperation among the world's peoples. But not everywhere could new channels be built. Although forty-eight nations belong to the WMA, some others do not. Russia is one of them—a major country without an eligible association.

Last month the WMA, while still largely a paper organization, had nevertheless appointed one of its three under secretaries, a Cuban. The honorary secretary is Dr. Charles Hill of Great Britain. Still to be chosen is the permanent secretary who will be located in New York. The WMA had adopted English, French, and Spanish as its official languages, had selected Czechoslovakia for its next delegates' meeting. Its twelve-man executive council was thinking about publishing a journal and was preparing reports on "standards of training of the medical profession," on "advertisement of cures and medicines in the lay press," and on related topics.

What's in it for American medicine? "Very little," says Doctor Bauer. "But we can contribute a great deal. There are about half a million doctors in the world who need our help."

Meanwhile, the WMA's American backers don't feel they can carry the load alone. "Individual physicians are going to be asked for help in meeting the WMA's operating costs," Doctor Bauer predicts.

—NELSON ADAMS

Federal Scholarships Sought For Medical Students

Parran suggests U.S. subsidies as a means of increasing the supply of physicians

• To combat a physician shortage he thinks may amount to 50,000 by 1960, Surgeon General Thomas Parran has broached a new scheme for getting more doctors from low-income families. Nub of the idea is a set of Federal scholarships. They would pay tuition and help pay maintenance costs of selected medical students in return for an option on their services after graduation.

The Parran proposal has already won the approval of Federal Security Administrator Oscar Ewing and many influential Congressmen. When the scheme was outlined at a recent meeting of the Association of State and Territorial Health Officers, members endorsed it in a resolution calling for U.S. subsidies in dentistry and nursing as well.

In describing this "system of scholarships for a sufficient number of medical students to insure that future Federal needs will be met," Doctor Parran said he was convinced that some such system was essential. Under the plan, Federal grants would be awarded on a wide geographic basis. Senators and Congressmen might do the nominating of candidates, but ability to pass a physical exam and to win acceptance by an accredited medical school would be the final test. The candidate would agree to render one month of Federal medical service for each month he was subsidized in school.

Said the PHS Surgeon General: "The plan might be broadened so that the student, if not required for active duty in the Federal service, would fulfill his obligation in a state or local public health service. He might even meet it by practicing in an area of his state designated as a deficit area by the appropriate state authority."

If such a scholarship plan can be worked out, the Surgeon General believes the schools themselves may need Federal help before they can handle additional students. But he warns: "Any such aid must insure that the conduct of medical education in every school continues to be the responsibility of medical educators." —MELVIN SCOTT

CUT IN of local physician on network program is about to take place. "When you ask me about phthisis, remember the 'ph' is silent," Dr. U. E. Zambarano warns WEAN (Providence) announcer checking the script.

Home-Town Doctors Take the Air

● "... And now, for a professional opinion on this matter of high bloodpressure, we turn to our guest at the microphone, Dr. John L. Smith ..." After such an introduction each week, 8 million New England radio listeners hear something new in medical broadcasting. The Yankee network's weekly program, "Doctor's Orders," winds up a brightly packaged, dramatic presentation by having each local station cut in to put a home-town physician on the air.

"As far as we know, this program is unique in giving local physicians a chance to take part in a network broadcast," says the executive secretary of a participating medical society. "We've found the public more receptive to the views of a local doctor whom they know and respect than to those of some man they've never heard of."

This formula has licked an old problem: how to avoid making the doctor on the air seem either (1) mediocre or (2) overly romanticized.

Broadcast at a peak audience time, 1:15 Sunday afternoon, the new network program features top-drawer script writing, better-than-fair acting, and good direction—a combination no local station could afford. Yet for the final five minutes, the switch to local physicians gives the program a down-to-earth flavor few network shows have.

Professional standards are guaranteed by the participation of local medical societies. These name the speakers and help to prepare the scripts. The network supplies the subject and a basic interview script. The latter is tailored to fit the ideas of the physicians who use it in each area. These M.D.'s are chosen, for example, by the Massachusetts Medical Society for the participating Boston station, by Connecticut's county societies for the four outlets in that state, by the Rhode Island Medical Society for broadcasts from Providence. Twenty-four stations comprise the total network.

Success came slow and hard to "Doctor's Orders," which began by falling victim to many of the special afflictions that haunt educational programs. In 1944, Station WEAN in Providence launched a weekly forum that brought members of the state medical society to the microphone. But somehow the audience exercised its inalienable right of spending that fifteen minutes somewhere else on the dial.

Then a local pharmacy was sold on the idea of sponsoring a show that cut the doctor down to five minutes, dressed up the remaining time with a punchy script and professional talent. People swamped the station with requests for copies of the program.

Today, "Doctor's Orders" is set up on a cooperative basis. A restricted list of businesses is invited to sponsor the program locally and prospective angels must win the imprimatur of the medical society. A straight-laced institutional plug is all they're allowed for their money, yet the first pharmacy to sponsor the program boomed its prescription business to the point where four additional pharmacists had to be hired.

"Doctor's Orders" marks a forward step in wedding entertainment and education. The idea of cutting local physicians in on a network program may well win imitators in other areas. —C. G. BENSON

The Tax Collector Says No!

Here's a sampling of the professional expenses that may not be deducted on your Federal income tax return

● Physicians looking for ways to cut taxable income sometimes pounce on Line 17, Schedule C, of their Federal income tax blank. There the eye-catching phrase "other expenses" tempts you to list as deductions all the miscellaneous costs that pop up in connection with your practice. Unfortunately, the revenue people don't always see eye to eye with you on what a professional deduction is—and you know who wins *that* argument.

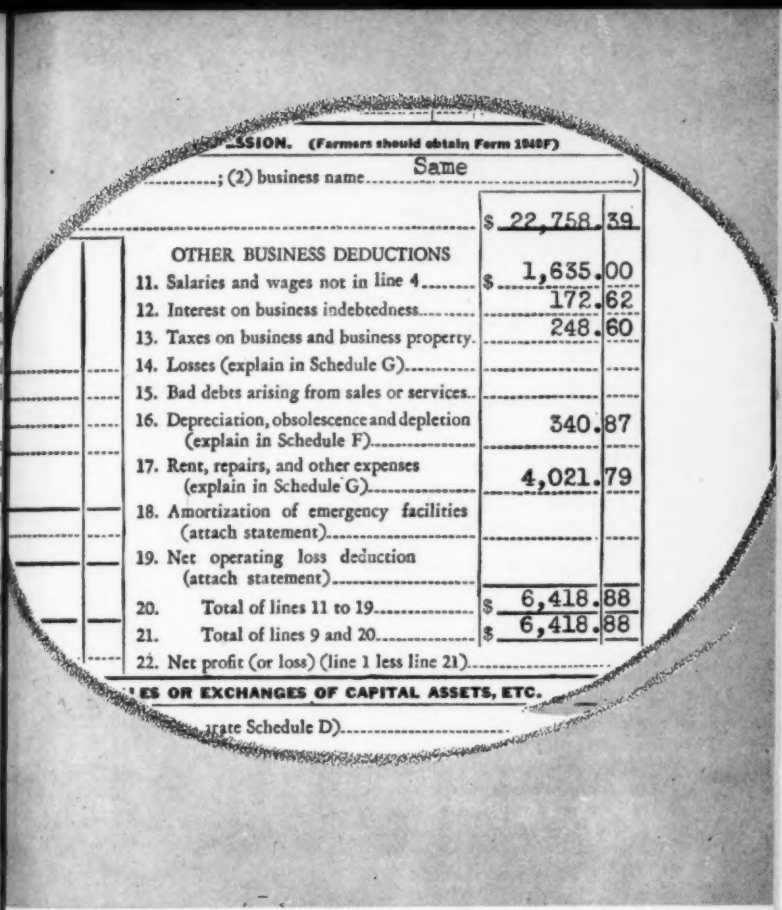
The cost of post-graduate courses, for example, can't be deducted. If you've attended a convention or two, you can lop those expenditures off your taxable income with the Treasury's blessings. But post-graduate courses are considered part of your training and just don't count as a professional deduction.

Some other items that look like naturals for the deduction column don't pass muster, either. If you commute between home and your office, for example, you can't deduct the transportation cost. And the laundry bill you pay to keep your uniforms clean is another deduction the Government won't honor.

Carnations Are Out

Perhaps, for the sake of a smart professional appearance, you wear tailor-made suits that you wouldn't otherwise have bought; even so, no part of their cost (or of any other bill to improve your personal appearance) can be checked off as a professional expense.

Legal costs also present some hair-splitting problems. Most doctors know that expenses of any court trial in which they have defended themselves against a malpractice suit are deductible from gross income. But if the court action is based on a criminal suit



...SSION. (Farmers should obtain Form 1040F)

...; (2) business name Same)

	$ 22,758.39	
OTHER BUSINESS DEDUCTIONS		
11. Salaries and wages not in line 4	$ 1,635.00	
12. Interest on business indebtedness	172.62	
13. Taxes on business and business property	248.60	
14. Losses (explain in Schedule G)		
15. Bad debts arising from sales or services		
16. Depreciation, obsolescence and depletion (explain in Schedule F)	340.87	
17. Rent, repairs, and other expenses (explain in Schedule G)	4,021.79	
18. Amortization of emergency facilities (attach statement)		
19. Net operating loss deduction (attach statement)		
20. Total of lines 11 to 19	$ 6,418.88	
21. Total of lines 9 and 20	$ 6,418.88	
22. Net profit (or loss) (line 1 less line 21)		

...ES OR EXCHANGES OF CAPITAL ASSETS, ETC.

...rate Schedule D)

connected with professional activities, a doctor can deduct the legal expenses involved only in the event of a successful defense. If he loses the case, he loses the deduction.

What if you're speeding to an emergency case and can't stop for a red light? You've violated the law for a good cause; yet the fine can't be used to reduce your taxable income. A penalty or fine for any statutory violation, whether in line of duty or not, is a burden the Government refuses to share.

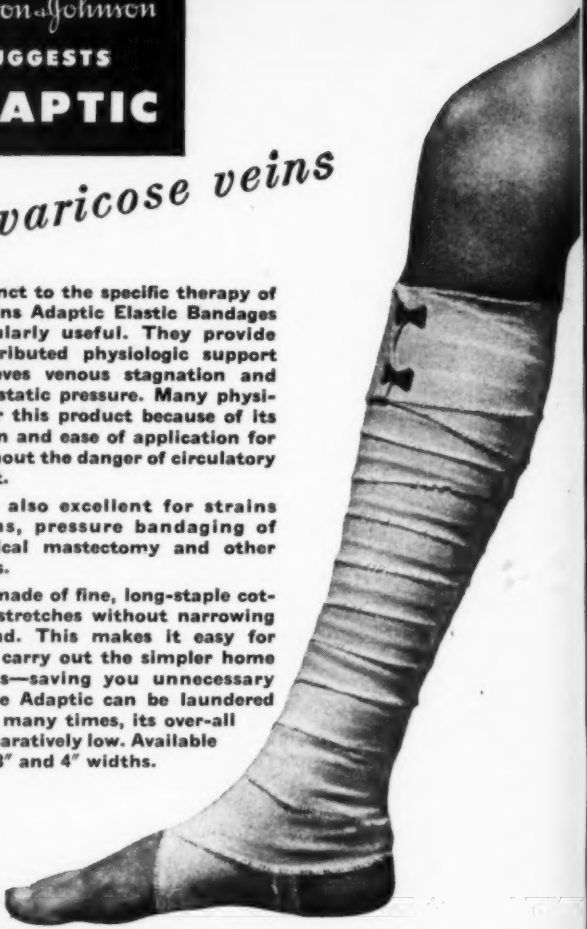
—J. D. OBERRENDER

Johnson & Johnson

SUGGESTS

ADAPTIC

for varicose veins



As an adjunct to the specific therapy of varicose veins Adaptic Elastic Bandages are particularly useful. They provide evenly distributed physiologic support which relieves venous stagnation and back hydrostatic pressure. Many physicians prefer this product because of its even tension and ease of application for lay use without the danger of circulatory impairment.

Adaptic is also excellent for strains and sprains, pressure bandaging of burns, radical mastectomy and other applications.

Adaptic is made of fine, long-staple cotton which stretches without narrowing when wound. This makes it easy for patients to carry out the simpler home applications—saving you unnecessary calls. As the Adaptic can be laundered and reused many times, its over-all cost is comparatively low. Available in 2″, 2½″, 3″ and 4″ widths.

ADAPTIC—*the* Johnson & Johnson ELASTIC BANDAGE

When Your Patient Balks at a Psychiatric Consultation

A physician suggests ways to take the curse off referrals for psychiatric care

• They tell of the family physician who was threatened with a lawsuit and almost talked out of town. He hadn't done anything so safe as setting a fracture improperly or writing the wrong dosage on an Rx blank. All he did was try to refer an eccentric old lady to a psychiatrist. She told everyone who'd listen that the doctor had implied she was crazy.

Which pinpoints a mounting problem for many a G.P. today: how to suggest a psychiatric referral without alienating the patient.

Sophisticates among your clientele are likely to take it with good grace when you broach the matter in some such manner as this: "Since you're in sound shape physically and since your trouble seems to be some basic emotional difficulty, I think a psychiatrist can do more for you at this point than I can." But to other patients, even this mildly worded statement raises some menacing bogeys.

Some may retort: "Why should I go to that kind of doctor? I'm not crazy!" This gives you a chance to explain that psychiatrists' offices are not used for treating crazy people. You can explain that patients who visit a psychiatrist do so for help with personal problems.

Sometimes the stumbling block is not prejudice against the specialist but fear of high fees. This is your cue to point out that the patient might pay $100 or more for an operation to relieve a disability; he should not, therefore, balk at that amount for a less painful, less dangerous procedure directed toward the same end.

To rationalize the postponing of psychiatric care, some patients say they've heard that psychotherapy requires extended daily interviews. They say they can't afford all that time. To which the practitioner who knows the score replies that only a small proportion of psychiatrists practice psychoanalysis, and that even among analysts, a growing group favors "brief therapy." Among non-analytic psychiatrists, the one-visit-a-week schedule is the rule. Then too, the psychiatrist can

[*Continued on* 163]

Careful–That's a Contract!

Here are the ground rules for avoiding legal tangles when you make business agreements

• A contract is like a pregnancy. It is more easily begun than terminated.

What's more, it's not always recognizable in its early stages. Most medical men are well aware that a contract may be oral as well as written. Not so well known is the fact that some contracts don't have to be put into words at all; they may be merely implied by the conduct of the parties concerned.

The average physician constantly enters into contracts without recognizing them as such. Suppose, for example, that you hire a new nurse, discover that she doesn't fill the bill, and discharge her at the end of the first week.

One nurse who had been thus discharged sued for six months' salary. She complained that she had been induced to leave her previous position by the assurance of at least half a year's employment. The doctor didn't think he'd been that definite; but on the advice of his lawyer, he settled out of court by paying her two months' salary.

Or suppose you let an ex-service colleague use part of your office "until he can get located." Since he's a friend of yours, and since you expect him to stay but a short time, you charge him nominal rent. Then suddenly you find that you need the space. If your friend has trouble finding new quarters, you may find yourself an unwilling landlord for many months. The informal agreement may be legally binding.

A salesman may persuade you to try out a rebuilt fluoroscope "on sale or return." He assures you orally that you're under no obligation whatsoever. But "on sale or return" is not quite the same as "on approval." In the event of damage to the machine, you may be held responsible. To avoid a knotty legal problem, your lawyer may advise you to settle the claim.

The best way to steer clear of such contract entanglements is to follow these basic rules:

---

*Arnold G. Malkan, LL.B., *author of this article, is an instructor in business law at the City College of New York and a practicing Manhattan lawyer.*

1. Read every document you sign—before you sign it. At a later date, a court will ignore any contention that you had no time to read the fine print in clause 12(c). If you're too busy to read a document in full when it's presented for your signature, put it aside until you have time to absorb every agate-type subsection.

2. Make your agreements brief. The briefer a written contract can be made (while still covering every contingency), the better you can trust your understanding of its terms.

3. Assume as few long-term obligations as you can. No man is a prophet. Arrangements that now seem desirable may be outmoded next year. During the current inflationary boom, try to keep financial obligations on a short-term basis.

4. Put your agreements in writing. Legally, you gain nothing by ducking a written contract. On-paper agreements actually protect you by specifically delimiting your obligations.

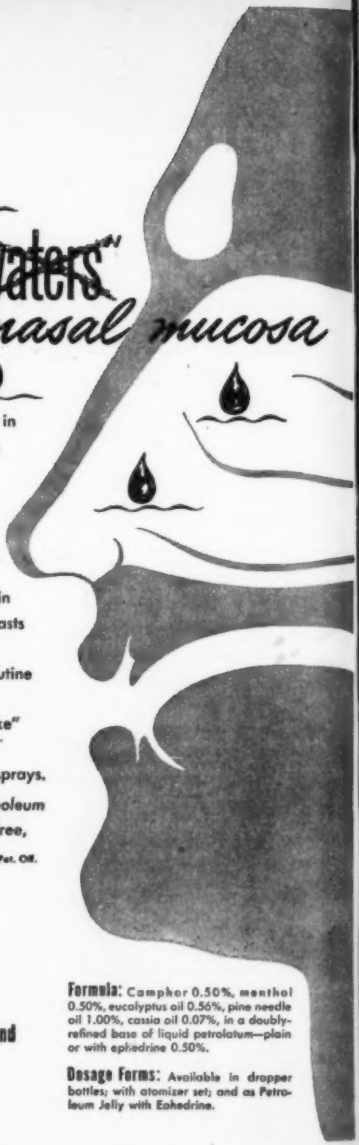
5. Do not rely on oral promises. Though they are sometimes legally binding, they're hard to prove. If you *must* work under an oral arrangement, at least recognize the risk that you may not be rewarded as promised.

6. Don't rush into a business arrangement without thinking about

"Just a minute, there. I was here first!"

For the Coryza Patient . . .

"oil on troubled ~~waters~~" nasal mucosa



When a cold strikes and nasal membranes react in stormy protest (turgescence, hyperesthesia, etc.) *"Pineoleum"** Compound's emollient oils frequently bring gratifying relief and protection. Gently spreading an adherent, oily film over irritated mucosa, it "seals in" the natural moisture, without impairing the efficiency of mucociliary defenses. While rapid in onset, *Pineoleum's* protective action long outlasts that of many aqueous sprays — and has been established, clinically, as perfectly safe for routine adult use.[1,2] It is particularly indicated in the precursor stage of the rhinitides, in "desert-like" climates (common in heated apartments and homes) and following treatment with aqueous sprays.

For the restoration of patent nasal airways, *Pineoleum* with Ephedrine provides a potent, but rebound-free, dosage of ephedrine.

*Reg. U. S. Pat. Off.

1. Griesman, B. L.: Arch. Otolaryngology, 39:124, 1944.
2. Novak, F. J., Jr.: Arch. Otolaryngology, 38:241, 1943.

BAYBANK

PINEOLEUM compound

PLAIN OR WITH EPHEDRINE

BAYBANK PHARMACEUTICALS, INC.

New York 4, New York

Division of Chesebrough Mfg. Co. Cons'd.

Formula: Camphor 0.50%, menthol 0.50%, eucalyptus oil 0.56%, pine needle oil 1.00%, cassia oil 0.07%, in a doubly-refined base of liquid petrolatum—plain or with ephedrine 0.50%.

Dosage Forms: Available in dropper bottles; with atomizer set; and as Petroleum Jelly with Ephedrine.

all its ramifications. A young physician recently bought a general practice, including office equipment, for $4,500. In his haste to close the deal, he signed the contract with only vague oral promises from the landlord's agent that he would soon be rented additional living quarters. The practice has proved to be eminently satisfactory. But the doctor faces the uncomfortable prospect of living in his small office for a long time.

7. When treating dependent patients, make your business arrangements with the persons who support them. Suppose you're operating on a widow who is supported by a prosperous son-in-law. Try to see that the son-in-law authorizes the operation and asks you to bill him directly. In this situation, even an oral promise is better than none.

A variant of this rule was applied by a noted New Orleans orthopedist. He had been engaged by the Nashville Bridge Company to treat seven employes who had fallen thirty feet to the floor of a steel tank when their scaffold collapsed. One man died, but after seven months of treatment the others were restored to health.

The bridge company then advised the surgeon to send his bill to the insurance company that carried its workmen's compensation policy. This he refused to do, pointing out that he had been retained by the bridge company. In his subsequent action against the bridge company, he was awarded $6,500.

8. Don't be an accommodation endorser. "Neither a borrower nor a lender be" was sound advice as far as it went. But if you are unprepared to make a loan directly, it is rarely wise to give a man your endorsement. If he defaults, the creditor can sue you directly, and probably will, since you're financially more responsible than his debtor.

9. Shy away from purchases on time, except for equipment essential to your practice. Installment buying is apt to be high-cost buying. What's more, drastic legal remedies are often concealed in the fine print of installment contract.

Don't try to be an expert in two professions. Even a trained lawyer will entrust his personal legal problems to another lawyer. If a business arrangement isn't crystal clear, consult your attorney *before* you become involved in it

—ARNOLD G. MALKAN, LL.B.

* HANDITIP *

Heat Source

A bit of steel wool wrapped around an old forceps makes an excellent source of heat when dipped into alcohol and lighted. It can be used over and over again. I've found that for many purposes this beats matches or even Bunsen burners.

—M.D., OHIO

* * *

Physicians to Feel Effect of New Diabetes Association Drive

National unit hopes to discover 'unrecognized' diabetics, ease doctor's instructional problem

• In the next year or two, physicians will note more patients asking about diabetes. Some of them will be surprisingly well informed on the subject. Probable result: more cases treated and more cooperation while treating them.

If you spot the trend in your own practice, you won't have far to look for the cause. The eight-year-old American Diabetes Association has launched a big, new expansion program. Last month the ADA had seven component societies and about 1,000 members, most of them doctors. Next year it hopes to have forty-two component groups and comparably larger membership.

One sparkplug of the drive will be a new magazine, the ADA Forecast. Backed by a gift of $100,000, the magazine aims to (1) ease the physicians' job by telling diabetics what they should know about taking care of themselves; (2) band diabetics together to help each other; and (3) induce more laymen to have themselves checked for the disease.

Sample articles that the ADA feels will help to make diabetics better patients touch on such subjects as diet, exercise, reactions, and coma. The ADA Forecast plans also to report such news as the recent survey of Oxford, Mass., which is the basis for current estimates that there are a million unrecognized diabetics in the U.S. today.

ADA officers do not contemplate a huge fund-raising campaign but are eager for affiliated units to induce well-heeled diabetics to help pay for care of the less well-off. Current cost to the paying patient varies from a low of about $80 a year to a top, in uncomplicated cases, of about $300. An approximate breakdown of the minimum total: $20 for insulin, $20 for medical fees, $40 for laboratory fees.

As for mass detection programs, the ADA does not have the money to put them on. The Public Health Service is presently surveying Jacksonville, Fla., and Brookline, Mass., as it did Oxford. The ADA hopes its component societies will inaugurate their own local studies.

—E. K. BUCHANAN

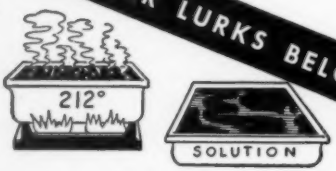
FREE of the Danger Zone in '48?

You can never tell when the blood stream of a patient carries spore-bearing bacteria. Guard against the danger of cross-infection by autoclaving all instruments and other materials that come in contact with any blood stream.

PELTON HP AUTOCLAVE

brings hospital safety to your office. Compact, fully automatic, beautifully finished, it assures patients of modern care.

DANGER LURKS BELOW 250° MOIST HEAT



Boiling does not destroy spore-bearing bacteria. Chemicals may be effective if maintained long enough. Autoclaving (moist heat at 250° F.) is the practical answer. Write today for your copy of the informative booklet, "A-B-C of Autoclave Sterilizing."

PELTON

PROFESSIONAL EQUIPMENT SINCE 1900

THE PELTON & CRANE CO., DETROIT 2, MICH.

Useful Hints on Insuring Your Car

Check your current policy against these down-to-earth rules for low-cost coverage

Although the financial hazard of accidental injury is the most serious consequence of automobile ownership, your investment in the vehicle itself needs protecting, too.

A standard fire and theft policy covers loss or damage to your car from fire, lightning, theft, larceny, robbery, and pilferage. It affords some insurance against damage or loss while the vehicle is being transported. And it usually covers theft of tools from the automobile as well. In addition, it usually pays $5 a day ($150 aggregate limit) toward the cost of hiring a car when the policyholder's car has been stolen.

Even broader coverage can be bought under a comprehensive fire and theft policy. This covers such additional items as damage from smoke, scorching, staining, and spotting. It insures against losses from vandalism, malicious mischief, strikes, and almost any damage wilfully inflicted on the vehicle. Not only theft but also damage from attempted theft is covered.

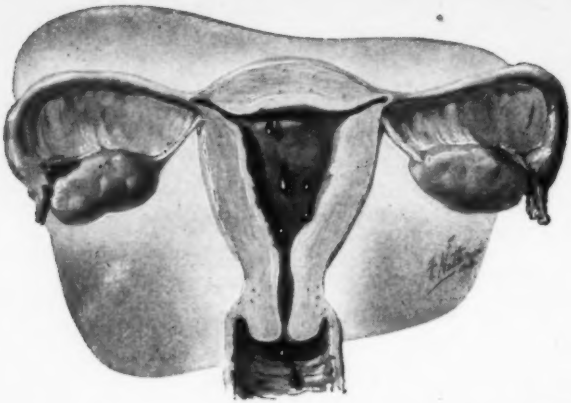
The cheapest way to insure your car is by means of the regular fire and theft policy. But the difference in premium for the comprehensive contract is relatively so small that most owners find it advisable to buy the broader policy.

A comprehensive fire and theft policy has relatively few exclusions. Those it does have are collision with another object; wear, tear, freezing, and mechanical breakdown; damage to tires unless by fire or theft.

Fire and theft policies are written in two ways. Under one form, the words "actual cash value" are used in the policy as the amount of insurance. A second type of policy names a specific amount. "Stated-amount" policies often cost far more than the "actual cash value" kind; yet at the time of loss a stated-amount contract will pay you

---

**Here are practical suggestions on buying fire, theft, and collision insurance for your car. The article (copyright 1948 by Philip Gordis) approximates a portion of Mr. Gordis' book, "How to Buy Insurance" (W. W. Norton & Co.).*



Functional Uterine Flooding

Some years ago it was noted that the administration of some crude liver extracts for treatment of anemia in cases with excessive uterine bleeding produced a lessening of the flow. This led to the isolation of an active anti-menorrhagic factor from the sterols of the liver. Very good results have been obtained from the use of this ANTI-MENORRHAGIC FACTOR (ARMOUR) in the control of functional uterine bleeding. Such bleeding is most common in patients approaching the climacteric or during adolescence but it may occur at any age. Usually it is menorrhagic in type but may be intermenstrual or metrorrhagic. There may be complete irregularity in the menstrual function. ANTI-MENORRHAGIC FACTOR (ARMOUR) is recommended in all these varieties provided there is no underlying organic factor such as tumor.

During excessive flooding massive dosage may be indicated—8 or more glanules t. i. d., up to 50 per day. The most advantageous time to start treatment, however, is about two weeks before menstruation, giving 2 or more glanules t. i. d.

Literature upon request.

ARMOUR

Anti-Menorrhagic Factor

Have confidence in the preparation you prescribe—specify "ARMOUR"

THE *Armour* LABORATORIES

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

no more than your car's actual cash value, regardless of the amount specified in the policy. Furthermore, if the amount named in the policy is less than the actual cash value at the time of the loss, the company is liable only for the lesser figure. It's usually wiser, therefore, in most cases, to purchase the cheaper policy.

To provide against collision damages (not included in the comprehensive fire and theft contract) additional coverage must be bought. The most common method of writing such coverage is to have the insured bear some part of the collision loss himself. This is done by setting a deductible figure of $25, $50, or $100. The company is then liable only for damages in excess of that figure.

Rates for this insurance decrease sharply as the deductible figure goes up. Collision insurance with a $25 deductible provision may cost as much as $60 a year. But if the same automobile is insured with a $50 deduction, the premium will be only about $40.

A Thrift Method

Most car owners can meet the cost of small collisions; so buying insurance with a deduction of $50 or $100 is an inexpensive way to get protection against heavy damage in a serious collision.

There are several important do's and don't's to remember in buying auto insurance. When you apply for a policy, be sure to give all the information asked for, since major gaps or misstatements on your application blank may enable the company to resist a claim under the policy later.

Give an accurate description of your car, the city in which it is garaged, and your occupation. Indicate whether you use the automobile professionally. If any other company has refused, canceled, or declined to renew a car insurance policy in your name, make that fact known on any application that calls for it.

Temporary Suspensions

If you don't use your car during certain months, you can suspend your liability and collision insurance by notifying the company. If the period is longer than sixty days, you'll get a rebate.

Should you take your car outside the United States, its territories or possessions, Canada, or Newfoundland, be sure to notify your insurance carrier. Your policy does not cover losses outside these areas unless specially endorsed.

By buying your insurance from a dividend-paying company, you can save about 20 per cent on your automobile policy. If you're now carrying car insurance in a company that pays no dividends, wait until the policy comes up for renewal before having it rewritten in a dividend-paying company.

—PHILIP GORDIS

ANNOUNCING...

THE NEW RAYTHEON *Microtherm* CONSOLE

For Modern Microwave Radar Diathermy

In the model CMD-5 Microtherm, Raytheon offers more than just Federal Communications Commission approval. It brings to the doctor *microwave radar diathermy* ... a completely new, scientifically researched post-war tool which greatly expands the science of heat therapy.

Microwave diathermy offers the following features:

- A high degree of absorption.
- Penetrating energy producing deep heating.
- Produces a desirable temperature ratio of fat to vascular tissue.
- Effective production of active hyperemia.
- Desirable relationship between cutaneous and muscle temperature.
- Controlled application over large or small areas.
- Eliminates electrodes, pads and danger of arcs.

ACT NOW to give your patients the benefit of this great advance in diathermy treatment. Ask your dealer to give you a demonstration of the new Raytheon Microtherm.

Approved by the F. C. C. • Certificate No. D-477. Underwriters' Laboratories.

RAYTHEON

Excellence in Electronics

RAYTHEON MANUFACTURING COMPANY

POWER TUBE DIVISION

WALTHAM 54, MASSACHUSETTS

Plain Talk in Giving Instructions

When the patient attempts to swallow a suppository, who's to be blamed for the error?

• Take it as a fact. Whatever *can* be misunderstood *will* be misunderstood. The patient's failure to understand instructions may be tragic. Or it can be funny.

There have actually been people who shook themselves instead of the medicine before taking. Women have given their babies orange soda instead of orange juice. Mothers have solemnly swallowed formulae that the doctors intended for their offspring. An instruction to apply cold to the abdomen in one case was interpreted as an order to eat large quantities of ice cream.

One patient, about to embark on a vacation, asked the doctor what to do for poison ivy. The physician gave him a bottle and said, "Apply this lotion to it." What happened? The patient applied the lotion to the plant instead of to his skin.

No use groaning at the "stupidity" of patients. The clarity of the instruction is an index of the doctor's intelligence, not the patient's. Every time the alert physician gives an instruction he applies this test: Can it possibly be garbled? If it can, restate it.

Explain or write out instructions so that one interpretation, and only one, is possible. Suppose you want to build up the patient's tolerance to a medication by increasing the dose at the rate of a drop a day. You might write on the Rx: "One drop after each meal; increase daily by one drop a day." Can that be misunderstood? It can and it will. In my own experience, almost half of all patients will take two drops after each meal on the second day, three drops after each meal on the third day. I have found it necessary to say something like this: "Tomorrow, take one drop after each meal; next day, take two drops after breakfast, one after luncheon, one after dinner; you'll thus be taking four drops that day. On the next day, take two after breakfast, two after luncheon, one after dinner. And so on."

Believe it or not, there are still thousands of persons who don't know that you swallow a capsule whole. They assume that the gelatin is merely a form of packaging. They open the capsule, float the

[*Continued on* 90]

contents on water, and drink that. If you have prescribed an enteric coated capsule, this procedure will defeat your purpose. Don't overlook this point in giving capsule directions.

Instructions for the use of suppositories should be graphically explicit. Some people insert them without removing the tin-foil wrapper. Others, as in the stock joke, actually do try to swallow them.

If you want the patient to have three doses a day, don't write "One after each meal" until you know it is his custom to eat three meals a day. America is full of people who take strange pride in the fact that they never eat breakfast. On the other hand, there are almost as many who think it uncivilized to go through a day without having consumed breakfast, luncheon, dinner, *and* supper.

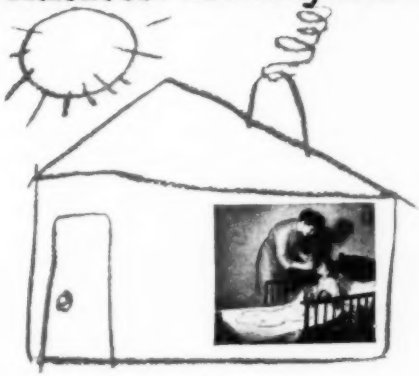
The popularity of scored tablets has introduced a new field for error. Suppose you want the patient to take enough phenobarbital during the day to take the edge off his nervousness. Three grains would make him sleepy. One and a half grains would be insufficient. You could, of course, prescribe the half-grain tablet and tell him to take four a day. However, that would considerably increase the cost to him, since 100 half-grain tablets cost almost as much as 100 one-and-a-half grain tablets. To achieve the desired effect, prescribe the standard, scored one-and-a-half grain tablets and write on the label "Half a tablet in the morning and a full tablet in the evening." Warn him specifically *not* to take a half tablet in the morning and the other half in the evening.

Another field for misunderstanding is the issuance of instructions for the preparation of mustard plasters, fomentations, turpentine stupes, and compresses. A doctor is wide open for a malpractice action if the patient by following his instructions (or a misinterpretation of his instructions), gets a burn or a blister from the hot application. When you say that the water should be "as hot as you can stand it," you leave a wide area for misunderstanding. Better to say that the water should be, for example, between 125 and 150 Fahrenheit *as measured by a thermometer*. If you write it down that way, there isn't much margin for error.

This brings up the whole question of written instructions. The advantages of handing the patient a sheet of paper bearing step-by-step instructions are too obvious to need emphasis. But here's the rub:

If you issue mimeographed or printed instructions, the patient

Here's the sulfadiazine that children actually like to take



Children have no reluctance in taking

Exceptionally flavorful, this fluid sulfadiazine is the ideal dosage form for your young patients. They take it willingly because it tastes good. And it relieves tired parents and busy nurses of the chore of crushing tablets and coaxing a sick child to swallow an unappealing mixture.

Important, too, is the more rapid absorption of Eskadiazine. Flippin and associates* have established that desired serum levels are attained in two hours, rather than the six hours required for sulfadiazine in tablet form.

Smith, Kline & French Laboratories, Philadelphia

Eskadiazine

*Am. J. M. Sc. 210:141, 1945

the outstandingly palatable fluid sulfadiazine for oral use

feels you're treating him by some kind of stock routine. You may have a fixed program for handling the ordinary cold. But the patient wants *his* cold treated, not the "average" cold. He resents the impersonal implication of a printed instruction sheet.

One answer is to prepare in advance a series of master instruction sheets appropriate for your type of practice. Procedures that lend themselves to this include post-tonsillectomy programs, routines for post-natal care, treatment of ringworm of the scalp, bathing a baby, treatment of a cold, diets for obese patients, post-operative convalescence, cooperation in the treatment of syphilis, management of diabetes, and many others.

Then have a letter company reproduce these instruction sheets on your own letterhead by automatic typewriter (the cost will probably be somewhere around $8 for the first 100, $4 for each subsequent 100). Your secretary can use a matching machine and ribbon to fill in the heading for each patient: "Special instructions for Mr. John Smith, December 22, 1947." The result is indistinguishable from instructions made to order for each patient. And the risk of misunderstanding is cut to the minimum.

When you hear a colleague being tortuously misquoted by a patient, chances are it's because the doctor did not realize the importance of plain talk in giving instructions.

—HENRY A. DAVIDSON, M.D.

in the endocrine ensemble

In the endocrine ensemble, the corpus luteum hormone is instrumental in stimulating progestational development of the endometrium, inhibiting abnormal uterine motility and fostering normal estrogen metabolism. When deficiency evokes the discords—habitual abortion, dysmenorrhea, premenstrual tension, meno-metrorrhagia —harmony may be restored with

PRANONE

SCHERING'S ORALLY EFFECTIVE
ANHYDROHYDROXY-PROGESTERONE

DOSAGE:

Habitual Abortion—PRANONE* Tablets 10 to 25 mg. daily, increasing to 30 to 75 mg. during periods of "calculated menses" or stress; treatment should be continued into the sixth month of pregnancy.

Dysmenorrhea—PRANONE 5 to 10 mg. once to three times daily for eight to ten days preceding onset of expected menses.

Premenstrual Tension—PRANONE 10 mg. once or twice daily beginning 10 to 14 days before menses.

Meno-metrorrhagia—PRANONE 10 mg. two to three times daily during the last half of the menstrual cycle, repeating the dosage during several successive cycles.

is available.

For parenteral corpus luteum therapy
PROLUTON*—progesterone in oil—

PACKAGING: PRANONE Tablets of 5, 10, and 25 mg., in boxes of 20, 40, 100 and 250 tablets. PROLUTON in ampuls of 1, 2, 5 and 10 mg., in boxes of 3, 6 and 50 ampuls; multiple dose vials of 10 cc. containing 25 mg. per cc.

*®

Schering CORPORATION • BLOOMFIELD, NEW JERSEY
IN CANADA, SCHERING CORPORATION LTD., MONTREAL

PRANONE

SCHERING

Do "human relations" lie within the physician's sphere?

From earliest times the doctor, like the spiritual adviser, has been the repository of the family's deepest problems. Today many of these can actually be treated with new scientific accuracy and improved medical therapy. For example, the frequent marital and family dislocations brought about by the approaching menopause.

Modern oral Conestron administration can tide most women through this physical adjustment of the menopause with a minimum of physical distress or emotional unbalance, give back a feeling of well-being that restores them to their families and themselves.

• • •

A new booklet for the physician's distribution "*Through One of Life's Progressive Changes*" will help patients and their husbands arrive at better understanding of this natural change. Copies free to physicians on request.

Conestron®

ORALLY ACTIVE • WELL TOLERATED

Natural conjugated estrogens (equine). Two strengths— 0.625 mg. and 1.25 mg. Bottles of 100 and 1000 tablets.

WYETH Incorporated Wyeth® **PHILADELPHIA 3, PA.**

Pediatrics Survey Shows Up Gaps In Child Medical Care

Study nearing completion finds specialists poorly distributed, G.P.'s bearing the brunt

• Top-drawer pediatricians heard some blunt facts last month about child medical care. A million-dollar study engineered by the American Academy of Pediatrics was in its last lap, and advance reports on its findings were beginning to seep out.

Some of the facts dredged up by the two-year survey were old stuff to most medical men. Others were real startlers. For instance:

¶ The volume of child medical care bears little relation to the number of children in a given area. Alabama, for example, provides only half as much medical care for children as the far less populous Maryland-District of Columbia region.

¶ Mainstay of present-day child medical service is still the family physician. He provides 75 per cent of all private care given to youngsters. Pediatricians supply only 12 per cent. The remaining 13 per cent is given by specialists in other fields.

¶ Distribution of pediatricians is notably spotty. One-third of all such specialists are located in New York, New Jersey, and Pennsylvania. Half of all pediatricians practice in cities having medical schools. A full three-quarters live in cities with more than 50,000 population.

The AAP study, which academy officers call "one of the first attempts on such a scale ever undertaken by private medicine to take stock of its own affairs," will eventually cover every U.S. community. It's being conducted in cooperation with the Public Health Service and the Children's Bureau. The hoped-for result: a systematic program for improving child medical care. Once it has been crystallized, pediatricians will put their own committee to work to get action.

Financed by foundations, medical societies, pharmaceutical houses, state health departments, and the pediatrics academy itself, the study has had phenomenal cooperation from medical men. Three-fourths of the physicians and dentists who received intricate questionnaires sent in the data requested ("How far from your office is the nearest hospital that admits

child patients? How often in the past year have you called in a pediatrician to see a sick child with you?" etc.). Among pediatricians, the response neared 100 per cent.

The survey unit discovered that the G.P., predominating as he does in child care, is still concerned primarily with treating the sick. Seventy-four per cent of the time he spends with child patients is devoted to existing ailments. On the other hand, the pediatrician spends 54 per cent of his time caring for well children. His patients may include youngsters as old as 15 and 16.

Regional discrepancies bob up in preventive child care. In the Pacific states, more than two-thirds of pediatricians' visits are for health supervision. The number of well visits in relation to child population is higher there than anywhere else.

This stress on preventive service is reflected only slightly in medical school curricula, the survey found. Medical training, it points out, is still "chiefly concerned with disease and very little, if at all, with . . . helping to create a healthy, happy child."

The "precarious financial situation facing our medical training centers today" was reported to be bad news for pediatricians in particular. Dr. John McK. Mitchell, who visited every U.S. medical school in the course of the survey, said that pediatric department budgets range from zero to $98,000. The average is $24,000.

[*Continued on* 100]

now! **improved treatment**

for ***coryza***
sinusitis
rhinitis
nasal congestion

'PROTHRICIN'

antibiotic nasal decongestant

because:

1. 'PROTHRICIN' decongestant contains *tyrothricin* (0.02%), potent, nontoxic topical antibiotic with wider antibacterial scope than the sulfonamides; quicker, more prolonged local antibiotic action than penicillin; low surface tension; greater permeability and stability than penicillin.

2. 'PROTHRICIN' decongestant maintains its antibacterial efficiency even in the presence of pus and mucus.

3. 'PROTHRICIN' decongestant serves to re-establish normal intranasal function since it is isotonic, with a buffered pH of 5.5-6.5, does not impair normal intranasal physiologic processes, and does not interfere with ciliary activity.

4. 'PROTHRICIN' decongestant is clear and free-flowing, unlike intranasal sulfonamide suspensions, and does not form mucosal crusts that may block drainage.

5. 'PROTHRICIN' Antibiotic Nasal Decongestant also contains 'Propadrine' hydrochloride (1.5%), a highly efficient vasoconstrictor, notably free from undesirable side-effects of ephedrine and its analogs.

SHARP & DOHME

Supplied in 1-ounce bottles with dropper assembly

SHARP & DOHME, PHILADELPHIA 1, PA.

8 OUT OF 10 CHRONIC SHOW IMPROVEMENT

When the results in all published cases of arthritis treated with Ertron Steroid Complex, Whittier are analyzed it is found that 82.2% showed significant improvement. Reporting on a series of 158 cases of proved arthritis treated with Ertron primarily, plus orthopedic appliances and physical medicine in association, investigators found that "in 91.8% of the cases improvement of some degree was evidenced while complete failure occurred in 8.2%." For a complete resume of the literature, see "A Report to the Medical Profession." A copy will be mailed to you on request*

*A Clinical Study of 180 Cases of Arthritis—Magnuson, P. B., McElvenny, R. T., and Logan, C. E.—J. Michigan State Med. Soc. 46:71 (January) 1947.

ERTRON is a Registered Trade Mark of Nutrition Research Laboratories

ARTHRITICS

Each capsule of Ertron contains 5 milligrams of activation-products having antirachitic activity of fifty thousand U. S. P. units. Biologically standardized

ERTRON

NUTRITION RESEARCH LABORATORIES

CHICAGO

As a matter of fact, pediatric training in general needs a vast face-lifting, the survey team concludes. One-half of all family doctors have had virtually no hospital training in child care, it points out. And of all the pediatricians in private practice, 25 per cent have had either no pediatric interneship or less than a year thereof.

What will come of all this fact-gathering? No clear-cut answer is expected until complete results are published next summer. While the survey has been going on, some private physicians have been heard to wonder whether the results will be pounced on by a Government eager to reshape medical practice. A number have looked askance at the PHS-Children's Bureau connection with the study. But Dr. John P. Hubbard, survey director, is quick to assure doubters that the final recommendations will be the pediatricians' own.

Says Dr. Warren R. Sisson, chairman of the AAP committee that supervised the monumental investigation: "Undoubtedly legislation will be needed to correct many of the existing deficiencies. But legislation based on thorough, systematic analysis done in the scientific manner will be sound legislation." To which a practicing M.D. last month added: "I hope so."

—C. F. LUCAS

RAY-FORMOSIL

FOR THE TREATMENT OF

ARTHRITIS and RHEUMATISM

73% Benefited

In one series of clinic-treated cases of atrophic, hypertrophic and mixed arthritis—with best results in hypertrophic and fibrositic types.

Ray-Formosil for intramuscular injection is clinically proved, effective treatment in most cases of Arthritis and Rheumatism. It is a non-toxic and sterile, buffered solution containing in each cc. the equivalent of:

FORMIC ACID . . . . . **5 MG.**
HYDRATED SILICIC ACID . . . . . **2.25 MG.**

Descriptive clinical literature will be furnished upon request. If your dealer cannot supply you, order direct. 1 cc. Ampuls—12 for $3.50; 25 for $6.25; 100 for $20.00.

RAYMER PHARMACAL COMPANY

PHARMACEUTICAL MANUFACTURERS, PHILADELPHIA 34, PA.

A Quarter Century Serving Physicians

Means Test Key Point of Contention In Health Bill Controversy

Its presence in Taft program draws Wagner supporters' fire

• Focal point of recurring attacks on the Taft health program has been the means test. Why have Wagner Bill backers concentrated on this feature of the plan? Senator Robert A. Taft thinks he knows the answer:

"It seems to me that the heart of the grants-in-aid program is the device whereby medical aid is made available to 20 per cent of the people rather than to 95 per cent. The means test is the nub of the conflict between socialism and free enterprise."

Largely by heaping abuse on the means test, the men wedded to Mr. Wagner's theories hope to defeat the Taft Bill and to push through their own measure that would give tax-financed medical care to all. Their two main talking points: (1) The means test sets up social barriers that makes the Taft measure a "charity bill"; (2) lack of standards for deciding who is medically indigent makes the means test impossible to administer.

To Taft Bill supporters, these charges simply don't square with the facts. And in parrying them, they show that the Wagner Bill also has a means test tucked away among its clauses.

John Q. Public's aversion to telling all about his current financial status is the tune plugged by most opponents of the Taft plan. "The average citizen," says Dr. Reginald M. Atwater of the American Public Health Association, "prefers to go deeply into debt, to do without, or to dangerously delay medical services rather than submit to a financial investigation and accept charity medical care."

"The difficulty about the means test," adds Sen. Claude Pepper, "is the embarrassment of the ordinary person in going up and admitting inability to pay, then having to ask for public charity."

The same dismal picture is painted by Elizabeth S. Magee of the National Consumers League. The Taft plan, she says, "seeks to remedy the condition of the least fortunate by treating their bodies while it breaks their hearts."

But such statements from the Wagner camp don't faze the senior sponsor of the bill for Federal

"We recommend a diet for the aged which
the normal adult diet, **and that**

White LABORATORIES, INC. Pharmaceutical Manufacturers, Newark 7, N. J.

approximates

vitamin B be increased" [1]

The increased carbohydrate intake of the elderly, as well as states of dehydration, poor economy of B complex factors, anorexia, depletion due to disease are listed by investigators as pointing the need for B supplementation in geriatrics.

The B factors most frequently found lacking in diets of the aged are supplied in White's Multi-Beta Liquid —an easy, convenient method of reinforcing such diets. In correcting B deficiencies, White's Multi-Beta Liquid helps promote appetite. The action of the B vitamins on intestinal motility is particularly important in the aged.

White's Multi-Beta Liquid provides all the clinically important B complex factors in a pleasant form—may be administered with fruit juice, milk or soft foods; imparts no odor or taste; pleasant to take directly. In bottles (with suitable droppers) of 10 cc., 25 cc. and 50 cc.

1. Meyer, J., Sorter, H., Necheles, H.:
Nutrition in the Aged, Gastroenter. *5*:403 (Nov.) 1945.

Multi-beta *Liquid*

a helping hand for the aging patient

grants-in-aid. Says Senator Taft: "The excitement about the means test is simply a red herring. In my opinion, the only justification for free medical service at the taxpayers' expense is the inability of the recipient to pay for it. The amount of his income, in these days of income deductions and social security, is usually a definite, ascertainable figure.

"In our public housing program, for example, we check the income of each person before public housing can be available to him. In millions of cases today, the means test is administered in an unobjectionable way."

Dr. Bradford Murphey of Colorado concurs: "I see no reason to stutter or stammer at the term 'means test.' We carry it out in our income tax situation. People support their government according to their means. There is nothing about the means test that carries with it an implication of unworthiness or charity."

The means test is especially familiar to doctors and hospitals, John H. Hayes of the American Hospital Association points out. Such a test is used every day "in determining whether needy patients shall receive medical or hospital care without charge or at partial cost. It is nothing more than a simple process for determining whether an individual is financially able to meet the cost of necessary care and for insuring that aid will reach the individual in need."

But Joseph P. Anderson of the

FOR SELECTIVE RELIEF OF SMOOTH MUSCLE SPASM

TRASENTINE • Trasentine-Phenobarbital

In the field of antispasmodics, Trasentine has earned a leading position because in therapeutic dosage, it selectively blocks parasympathetic impulses to the hollow viscera, without causing drying of the mouth or pupillary dilatation. This spasmolytic effect is reinforced by a direct inhibitory action on smooth muscle. Trasentine is available in forms to meet every need, as listed below—including a compound with Phenobarbital.

ISSUED ---------- Trasentine tablets 75 mg., ampuls 50 mg., suppositories 100 mg. Trasentine-Phenobarbital tablets contain Trasentine 50 mg., Phenobarbital 20 mg.

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

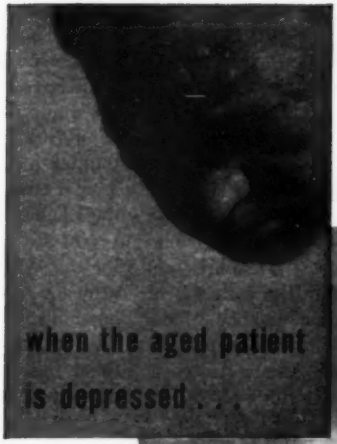
2/1336M TRASENTINE (brand of adiphenine) • T.M.Reg.U.S.Pat.Off.

American Association of Social Workers takes issue with the idea that a means test is a simple process: "In my opinion, the procedures to determine eligibility for assistance under this program would be cumbersome, costly, and demoralizing to the recipients. We are the group that would have the job of investigation. If the Taft Bill becomes law, a large number of social workers would have to be employed to administer this phase of the program."

Former OPA Administrator Leon Henderson believes "an investigator cannot investigate more than fifty cases a day." He adds: "If this bill is to assist 20 per cent of the population, between 600,000 and 1,200,000 man-days a year of the investigators' time will be required." Others point out that this would mean no more than 4,000 workers in the initial year.

The "insuperable" difficulty of administering the means test, according to Senator Pepper, is "laying down a general standard that will be fair to everybody and will properly define the medically indigent." Mr. Anderson adds his amen to that: "A formula for deciding when an individual should be declared medically indigent would be impossible to work out."

But Dr. Thomas Parran, a Taft Bill opponent himself, spikes these charges. A means test is difficult to administer, says the Surgeon General, but not impossible: "I know it is not impossible because of the experience we had in New York



the desired amelioration of mood can be achieved *safely* with Dexedrine.* Dexedrine can be depended upon to store mental alertness and zest for living.. Particularly important in the aged— Dexedrine has no significant effect on either blood pressure or heart rate.

Smith, Kline & French Laboratories
Philadelphia

Dexedrine
Sulfate
(dextro-amphetamine sulfate, S.K.F.)
tablets
elixir

The Central Nervous Stimulant of Choice

* REG. U.S. PAT. OFF.

State during depression days. A policy was developed for providing medical care for persons otherwise self-sustaining, especially rural families who had food, clothing, and shelter, but no cash on hand with which to meet medical costs. The program was successful."

Support for this view is voiced by Sen. Forrest C. Donnell, who says: "New Jersey, Missouri, and other states define the meaning of 'needy individual.' They have found it possible to administer vast sums of Federal and state monies, relying on the determination of eligibility at the local level."

Even if the means test weren't administratively "impossible," it would be an invitation to political meddling. At least that's the view of Dr. Allan M. Butler of Harvard Medical School, who says: "It is difficult to understand how the AMA could have ignored the fact that this bill would require a bureaucracy, an administrative expense, and opportunities for 'political medicine' far greater than would ever result from the Wagner Bill."

Not so, retorts Senator Donnell, for the Wagner Bill itself involves a means test. He quotes one of its headings as follows: "Provision of benefits for noninsured needy and other individuals." He adds: "The only way you can find out if a person is needy is by imposing some sort of test."

"I know of no other way," concedes Surgeon General Parran.

—THEODORE BROOKS

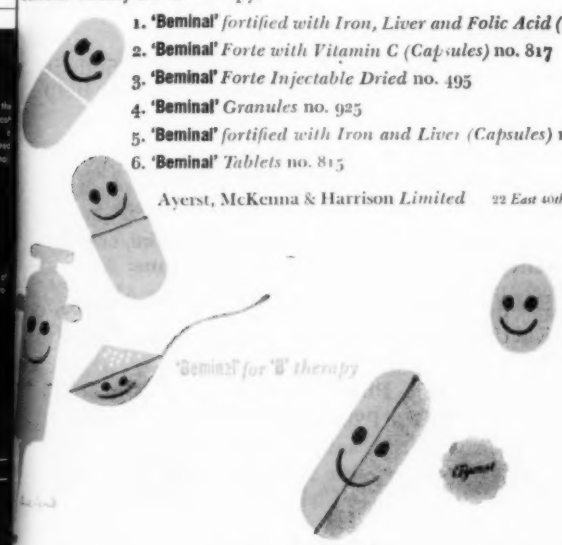
'Beminal' 6

Now there are 6

With the addition of **'Beminal'** fortified with Iron, Liver and Folic Acid, No. 821, the **'Beminal'** family now presents six distinctive forms and potencies for the effective treatment of vitamin **'B'** deficiencies. **'Beminal'** fortified with Iron, Liver and Folic Acid is suggested for the treatment and prevention of iron-deficiency anemias and certain macrocytic anemias as well as adjunctive therapy in pernicious anemia. Starting with the newest addition here are the six members of the versatile **'Beminal'** family for **'B'** therapy:

1. **'Beminal'** *fortified with Iron, Liver and Folic Acid (Capsules)* **no.** 821
2. **'Beminal'** *Forte with Vitamin C (Capsules)* **no. 817**
3. **'Beminal'** *Forte Injectable Dried* no. 495
4. **'Beminal'** *Granules* no. 925
5. **'Beminal'** *fortified with Iron and Liver (Capsules)* **no. 816**
6. **'Beminal'** *Tablets* no. 815

Ayerst, McKenna & Harrison *Limited* 22 *East 40th Street, New York* 16



THE ROLE OF KONDREMUL IN THE AGED

Constipation has long been one of the more frequent disorders accompanying old age, due to definite structural changes and a general slowing up of all the physiological functions.

As a result of these changes, the physician often finds it necessary to prescribe some medication that will help establish regularity.

KONDREMUL

(An Emulsion of Mineral Oil and Irish Moss)

. . . as the regulator of choice—is pleasant to take, creamy in consistency and satisfies the most fastidious.

KONDREMUL Plain (containing 55% mineral oil)

KONDREMUL with non-bitter Extract of Cascara (4.42 Gm. per 100 cc.)

KONDREMUL with Phenolphthalein—.13 Gm. (2.2 grs.) phenolphthalein per tablespoonful.

Canadian Distributors:
Charles E. Frosst & Co., Box 247, Montreal

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

THE E. L. PATCH COMPANY BOSTON, MASS.

No Pay for Internes, No Room for Residents: the $64 Poser

Chronic issues become acute in backwash of World War II

• One segment of American labor that isn't worried about the Taft-Hartley Act is the army of 20,000 physicians who serve as internes and residents in the nation's hospitals. Not that the profession's younger set doesn't have its own, unorganized worries. It's got plenty. The 1948 outlook is briefly this:

¶ For internes, continued low pay.

¶ For residents, standing room only.

The Interne Blues

The interneship situation is well stabilized statistically, though in a state of ferment economically. Fewer than 6,000 doctors are graduated each year, yet there are some 8,800 AMA-approved interneships. In fact, since many state boards approve 70- to 100-bed hospitals (the minimum for AMA approval is 100 beds), the actual number of legally approved interneships tops 9,000.

Part of the gap between the 9,000 interneship appointments and the 6,000 new doctors is filled by men who take two-year interneships. The 6,000 new graduates next June will account for about 8,000 interneships during the following two-year period. But this still leaves enough vacancies so that almost any approved-school graduate can find an approved interneship—provided he does not insist on a specific location.

8,800 Strong

The 8,800 AMA-approved interneships include about a hundred each in Army, Navy, Public Health Service and hospitals—the rest are in civilian institutions. There are, at present, no interneships in V.A. hospitals.

Although stipends (you can hardly call them salaries) are higher than ever before, the interne's pay scale still does not average more than $60 a month for the country as a whole. Since he works some 250 to 300 hours a month, this amounts to a rate of about 20 cents an hour, putting internes on the bottom rung of labor's financial ladder.

The real plutocrats among internes are those in Federal hospitals. An Army interne draws the

pay and allowances of a first lieutenant. An interne in a Naval hospital gets the stipend of a lieutenant (j.g.). Salaries in Marine Hospitals and PHS institutions average $155 a month.

Of the 764 AMA-approved civilian hospitals, 150 pay $100 a month or more. But seventy-two hospitals pay their internes nothing, and the largest group (203 hospitals) list internes in the $50 to $75 a month pay bracket.

Thanks or Cash?

This means that many an interne has to sell a pint of his blood to get enough money to buy his wife a birthday present. To which some hospitals answer: "The interne is learning; he's lucky he doesn't have to pay us for all that free instruction."

The internes retort that they have to dig out most of their own "learning" and that few attending M.D.'s are systematic about teaching the house staff. Furthermore, many an interne has sweated out jobs for private practitioners (deliveries, cast-cuttings, suturing, boil-lancing) for which the attending physician collects a fee and the interne collects thanks. Internes point out that apprentices generally earn while they learn—so why not doctors? Hospitals, they charge, actually make money from the labors of internes since private patients pay generously for each procedure that the 20-cent-an-hour interne performs. [*Continued on* 116]

The residency presents a problem of another color. Here is a buyers' market with a vengeance. Many hospitals report residencies booked for years to come. Never before has there been such a parade of doctors hammering at hospital doors for residency appointments. Here the approval of organized medicine is more important than a nod from the state licensing body—more important because organized medicine, not government, accredits toward specialty board examination.

In all, the AMA approves some 12,000 residencies. From the long waiting lists and from the cries of anguish rising from frustrated applicants, it would seem that doctors want at least 10,000 more residencies than are available.

Critical Spot

Shortage of appointments is particularly acute in the surgical specialties. The supply of approved residencies in general surgery is now 2,229; the demand is for about 5,000.

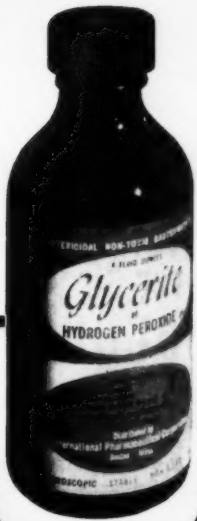
Number two shortage on the available residency lists is internal medicine, with 2,677 appointments. Number three is neuropsychiatry, where approved residencies total 1,470. After that, the figures get rapidly smaller, dropping to thirty-four approved residencies in proctology.

In a few fields, there are actually some vacancies. But these are mostly in such specialties as psychiatry and in non-approved state hospitals and private sanitaria. With more

Eliminate infection in

WOUNDS **ULCERS**
LESIONS **FISSURES**
ABSCESSES **CYSTS**

by simple topical application



Glycerite of Hydrogen Peroxide ipc
stable, long-acting, non-selective, bactericidal solution . . .

. . . Possesses the mechanical advantages of liquid and ointment types of medication . . .

. . . Hygroscopic, penetrates into and draws plasma from deeper parts of wounds, washing particulate matter to the surface . . .

. . . Aids granulation of healthy tissue and speeds healing processes . . .

. . . Non-toxic, non-irritating, non-sensitizing . . . Apply full strength as frequently as desired.

GLYCERITE OF HYDROGEN PEROXIDE *ipc*

Bibliography:

New Eng. J. Med.	234:468, 1946.
J. Invest. Derm.	8:11, 1947.
Annals of Allergy	4:33, 1946.
Science	105:312, 1947.
J. Bacteriology	Vol. 53, June, 1947.

Literature on request.

CONSTITUENTS:
Hydrogen peroxide (90%) 2.5%
8-Hydroxyquinoline 0.1%
Especially prepared glycerol q.s. ad. 120cc.
Supplied in four-ounce bottles

International PHARMACEUTICAL CORPORATION
132 Newbury Street, Boston 16, Massachusetts

than half of all senior medical students now setting their sights on specialization, the situation will certainly get worse before it gets better.

Some relief has been afforded by the expanding residency programs of the Federal Government. The Army offers 350 approved residencies, the Navy 200, and the Veterans Administration no less than 2,000. Nearly all specialties are represented. Most of the residency programs run for three years, though the armed services do have some short-term ones.

Fly in the Ointment

The joker is that Army and Navy residencies are open only to officers of the regular defense establishment, or in some instances to reserve officers who have filed application for regular commissions. Pay scale depends on rank; most residents will be in the second pay period.

The V.A. pays $900 the first year, $1,350 the second, and $1,800 the third, with an additional $600 a year if quarters are not provided.

In civilian hospitals, the residency pay scale runs the gamut from zero to $375 a month. There is often an automatic salary increase after the first year or at the time of upgrading from assistant resident to full resident.

Several changes in residency approval methods have been made recently by the AMA. No longer recognized are autonomous residencies in traumatic surgery, epi-

aqueous vitamin A superior to oil solution

New clinical and laboratory studies[1] corroborate previous investigations[2-4] proving that vitamin A in aqueous solution—as available in VI-SYNERAL VITAMIN DROPS—is more readily and more fully utilized than vitamin A in oily solutions.

500% greater absorption

average peak blood levels (infants)

aqueous A	1000 U.S.P. Units
oil A	200 U.S.P. Units

1/5 as much excretion

average fecal excretion (infants)

aqueous A	7% of ingested vitamin
oil A	38% of ingested vitamin

confirmed by

85% higher liver storage

total liver storage in 24 hours (animals)

aqueous A	7500 U.S.P. Units
oil A	4040 U.S.P. Units

vi-syneral vitamin drops

Each 0.6 cc. as marked on dropper supplies:

VITAMIN A	**5,000 U.S.P. Units**
VITAMIN D	**1,000 U.S.P. Units**
ASCORBIC ACID (C)	**50 mg.**
THIAMINE (B_1)	**1 mg.**
RIBOFLAVIN (B_2)	**0.4 mg.**
PYRIDOXINE (B_6)	**0.1 mg.**
NIACINAMIDE	**5 mg.**
PANTOTHENIC ACID	**2 mg.**

natural vitamins A and D in aqueous solution

In aqueous solution . . . contains no alcohol

Perfect miscibility with infant's formula, milk, etc.; no fish taste or odor.

Send for sample and literature

Available in 15 cc. and 45 cc. packages

1. Jl. of Pediatrics: 31:496, 1947.
2. Am. Jl. Diseases of Children: 73:543, 1947.
3. Science: 106:40, 1947.
4. Nutrition Reviews: 4:286, 1947.

U. S. vitamin corporation

casimir funk laboratories, inc. (affiliate)

250 east 43rd st. new york 17, n. y.

lepsy, or mental deficiency. But new standards have made it possible to give approval to specialized residencies in allergy, gastro-enterology, occupational medicine, and proctology.

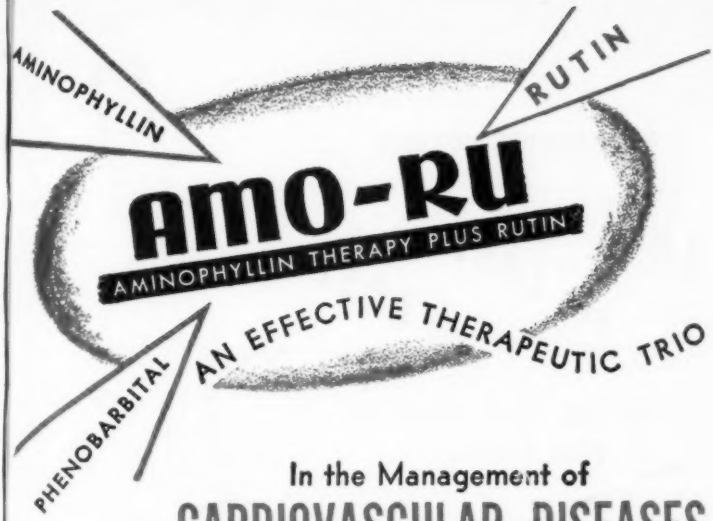
Residents have their gripes, too. Like internes, they complain that they often do work for the attending physician, who does not hesitate to pocket a fee for the fruit of their labors. They take a dim view of the rising tide of Blue Cross, since this means fewer ward patients and more private patients, with less chance of getting intimate clinical experience. Even in all-ward hospitals, residents feel they cannot compete successfully with junior attending surgeons in getting authority for non-routine operations.

Thus, though residencies are more in demand than ever before, there is no evidence that they are clinically more valuable. Indeed, many hospitals, spurred by the creditable motive of furnishing more residencies, are splitting services. This means that the amount of clinical material available to each resident will still further diminish.

—ROBERT BAKER, M.D.

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.



In the Management of

CARDIOVASCULAR DISEASES

Amo-Ru is a rational combination of Aminophyllin, Rutin and Phenobarbital. Aminophyllin for its vasodilating, diuretic, and myocardial action; Rutin with its tendency to restore and maintain normal capillary fragility, and to reduce the incidence of vascular accidents. Phenobarbital completes the combination with its sedative, antispasmodic, and vasodilating action in reducing nervous tension, apprehension, and arterial spasm.

Rutin has been found to increase the duration and intensity of the diuretic action of theophylline.

Amo-Ru is indicated in the treatment of coronary disease, congestive heart failure, arteriosclerosis and angina pectoris.

AMO-RU

Each tablet contains

Aminophyllin 1½ grs.
Rutin .....5 mg.
Phenobarbital ¼ grs.

SINCE 1883

SUTLIFF & CASE CO., INC.

210 SPRING ST., PEORIA, ILLINOIS

Better Care for the Sick Poor

Doctor's role in indigent care seen due for sweeping changes

• "The public and the profession have become enmeshed in a distressing and paradoxical situation. As the competence of the profession has increased, and as the public has learned to appreciate this and to desire its services, the costs of medical care have increased until they are beyond the resources of many."

A compelling issue is thus put into words by the Committee on Medicine and the Changing Order, of the New York Academy of Medicine. After long study, the committee offers this duplex solution:

1. Continue to buy medical care for the *totally indigent* out of public funds, but make greater use of private facilities.

2. Aid the *medically indigent* by helping to pay their premiums in voluntary health insurance plans that give comprehensive care.

Free care by private physicians is on the way out, says the committee; the needy are a responsibility of society, not of the individual doctor. Since the AMA took that stand in 1938, some communities have been charged by statute with medical care of the indigent. Elsewhere, the committee says, "the narrow spirit of the old poor laws still withholds aid from all who cannot prove they are paupers."

Care of the totally indigent varies widely in scope. Just before the war, local welfare units in half the states provided both home medical care and hospitalization; in twelve states, home care but not hospitalization; in two states, hospitalization but not home care. In five states, medical care was available only in almshouses, poor farms, or a state welfare home. Elsewhere the pattern varied according to county.

Salaried physicians (full-time or part-time) continue to do most of the work today. But there is increasing use of private doctors, with county societies acting as administrative agencies. In some places, a lump sum is paid annually in advance to the societies. They in turn distribute it among participating doctors. This arrangement was effective in twenty-eight out of 105 Kansas counties in one recent year.

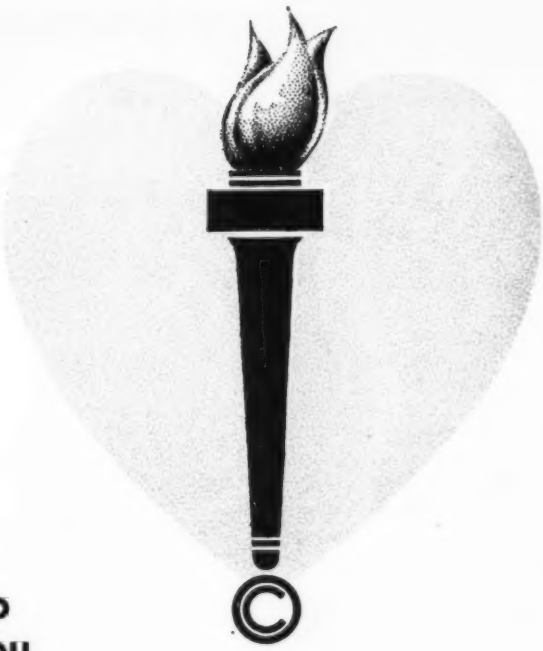
Though local government still carries the burden of indigent

care, some states are assuming financial and supervisory responsibility. By 1940, thirty-nine were sharing the work, generally through grants-in-aid. They were finding supervision difficult, since less than half had records showing services rendered, number of persons helped, or costs.

By 1943, New York State was paying 42.2 per cent of indigent medical costs. It places a ceiling on medical and hospital fees that a community may exceed only by assuming the extra costs. Indiana law requires the state public welfare department to review all county plans and to supervise their fee schedules. Rhode Island finances medical care of the indigent directly through working agreements with the medical, hospital, dental, pharmaceutical, and nursing societies. Pennsylvania, the District of Columbia, Hawaii, and Alaska also assume responsibility for indigents.

On the whole, says the committee, medical care programs for the poor are inadequately financed. Usually there are funds to pay only for general practitioner services. Economy is the watchword. Few communities can pay enough to attract superior physicians.

Another common drawback is lack of coordination. The municipal setup frequently prevents the doctor from working closely with tax-supported hospitals and public health units. Supervision is limited to preventing waste and keeping costs down, seldom to raising the



DO YOU KNOW WHAT THESE SYMBOLS STAND FOR?

Rexall
DRUGS

You can depend on any product that bears the name Rexall

More Americans died of heart disease last year than of injuries suffered throughout World War 2! This symbol is the battle flag in the fight against diseases of the heart and circulation — America's No. 1 Killer. NATIONAL HEART WEEK begins February 8. Join your local Heart Association. Give for research.

Another symbol is the familiar Rexall sign. Approximately 10,000 independent, reliable drug stores, the nation over, display it proudly. Simply it proclaims: in this store all drugs are laboratory tested—for purity, potency, uniformity — under the rigid Rexall system of controls. It proclaims also that every prescription is compounded with the highest pharmacal skill.

REXALL DRUG COMPANY
LOS ANGELES, CALIFORNIA
Pharmaceutical Chemists for More Than 45 Years

standards of care. Only a few communities have established medical advisory boards to review cases.

Free choice is largely restricted. Even where it exists, the committee says, it is a mixed blessing. Indigents sometimes fall into the hands of incompetent doctors. In some regions, unethical men even solicit the needy. The committee believes organized medicine could end such abuses if it were given supervisory powers in professional matters and a voice in determining procedures, rates, and payment methods.

The continuity essential to proper care is frequently lacking. The indigent patient often has one doctor in the home, another in the hospital. Some communities have ended that practice by assigning outpatient staffs to home service. In Syracuse, N.Y., for example, 165 hospitalized patients were discharged for home care at a total saving of $29,072.

One wholesome trend, says the committee, is increased recognition that indigent medical care should be the responsibility of the public health department and should not be distributed piecemeal among other local agencies. This trend has been accelerated by a Federal contribution, under the Social Security Act, of $20 million a year for public health work.

In the District of Columbia, the health department has been responsible for the indigent sick since 1937. Coordination of health, medical, and hospitals' services has resulted in better medical care, lower mortality, and reduction in costs.

More recently, Maryland gave its state health department control of a program of medical and nursing service for the indigent and medically indigent. The department contracts with physicians and hospitals for care. It is authorized to build institutions for the chronically ill. The professions are given a voice in forming policies. But determination of eligibility still rests with the public welfare department.

"Obviously," says the committee, "the medical care of the completely indigent must be entirely tax-supported. It is unlikely that government will in the near future subsidize their care by voluntary insurance plans, although this would remove distinction between those on relief and those paying their own way.

"The needs of the indigent should be met by improving the facilities in tax-supported municipal hospitals, and through municipal subsidies to approved nonprofit institutions. Cities should supply office and home care through a panel of physicians approved by the responsible municipal agency. Practitioners should be paid in the manner best adapted to the local situation. When prepayment plans are well developed, experiments may be tried in having the city pay premiums for the indigent."

[*Continued on* 130]

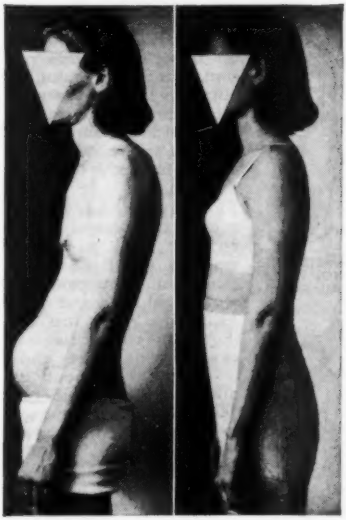
"CORSETS should be made to order for each INDIVIDUAL wearer"*

Spiesman,* in a study of the use of abdominal supports in treatment of visceroptosis, found that "girdles and corsets should not be taken from 'stock' but should be carefully made to order for each individual wearer."

More than 40 years ago, the Spencer Individual Designing System was founded on the principle that only an individually designed support can adequately meet individual needs.

That is why each Spencer Support is separately designed, cut, and made for each patient.

That is why the physician, in specifying Spencer, can prescribe—and GET—the individual design and degree of support required.



Patient under treatment for visceroptosis with symptoms without and with the Spencer Abdominal and Breast Supports individually designed for her.

For a dealer in Spencer Supports, look in telephone book for "Spencer corsetiere" or "Spencer Support Shop," or write direct to us.

*Spiesman, M. G., *Visceroptosis*, Rev. of Gastro. 7 : 218-234 (May-June) 1940.

Reynolds, Edward, and Lovett, R. W.: *An Experimental Study of Certain Phases of Chronic Backache*, J.A.M.A. 54: 1033-1043 (March 26) 1910: Ober, Frank R., *Corsets and Backache*, J.A.M.A. 116: 1909 (April 26) 1941.

MAY WE SEND YOU BOOKLET?

SPENCER, INCORPORATED

131 Derby Ave., Dept. ME, New Haven 7, Conn.

Canada: Spencer, Ltd., Rock Island, Que.
England: Spencer, Ltd., Banbury, Oxon.

Please send me booklet, "How Spencer Supports Aid The Doctor's Treatment."

Name ..... M.D.

Street .....

City & State 2-48

SPENCER *INDIVIDUALLY DESIGNED* **SUPPORTS**

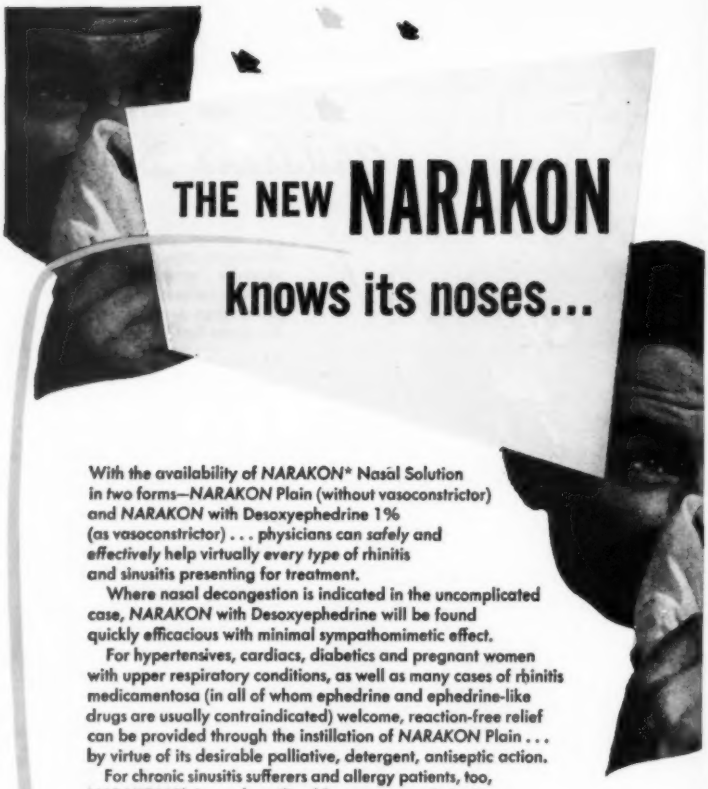
® FOR ABDOMEN, BACK AND BREASTS

The committee believes that completely free care for the medically indigent is obnoxious: "Self-supporting people who cannot pay for adequate care do not relish going on medical relief. These people are capable of paying *some* part of their average medical costs. Such payment would conserve their self-respect and might also overcome suspicions about the quality of anything that costs them nothing. Too, partial payment of medical costs by the medically indigent would lighten the taxpayer's burden.

"The needs of the medically indigent should be met by nonprofit insurance plans in which they pay only part of the premiums with the balance met by employers or by local, state, or Federal funds."

Few medical society plans as now constituted would meet the committee's specifications: "Complete coverage should be provided through panels of private practitioners or group practice units. Capitation payments for general practitioner service are to be preferred. Members of group practice units would be remunerated preferably by salary or income-sharing."

The committee believes that 50 or even 75 per cent of the premiums might be paid by a government agency—local, state, or Federal. "The medically indigent could then join the same plans as the middle-income populations," it says. "There would be no more difficulty certifying those eligible for such aid than under any other system of providing medical care." —ALLEN ELY



THE NEW NARAKON knows its noses...

With the availability of *NARAKON Nasal Solution in two forms—*NARAKON* Plain (without vasoconstrictor) and *NARAKON* with Desoxyephedrine 1% (as vasoconstrictor) . . . physicians can *safely* and *effectively* help virtually *every type* of rhinitis and sinusitis presenting for treatment.**

Where nasal decongestion is indicated in the uncomplicated case, *NARAKON* with Desoxyephedrine will be found quickly efficacious with minimal sympathomimetic effect.

For hypertensives, cardiacs, diabetics and pregnant women with upper respiratory conditions, as well as many cases of rhinitis medicamentosa (in all of whom ephedrine and ephedrine-like drugs are usually contraindicated) welcome, reaction-free relief can be provided through the instillation of *NARAKON* Plain . . . by virtue of its desirable palliative, detergent, antiseptic action.

For chronic sinusitis sufferers and allergy patients, too, *NARAKON* Plain can be utilized for potent, non-irritating, non-habituating rhinologic medication over extended periods.

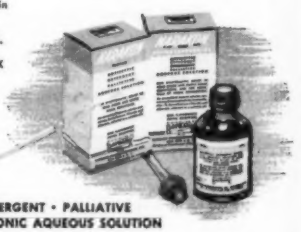
Composition: *NARAKON* Plain—Benzalkonium chloride (1:3500) and allantoin in an aromatized, isotonic solution buffered to a pH of 6; *NARAKON* with Desoxyephedrine—as the foregoing with *dl*-Desoxyephedrine (1%) added.

Supplied: *NARAKON* Plain or with *dl*-Desoxyephedrine (1%) in one fluidounce bottles—with dropper assembly.

BAYBANK

BAYBANK PHARMACEUTICALS, INC.
Division of Chessbrough Mfg. Co. Cons'd
17 STATE STREET, NEW YORK 4, NEW YORK

*Trade-Mark



ANTISEPTIC • DETERGENT • PALLIATIVE
SLIGHTLY ACID • ISOTONIC AQUEOUS SOLUTION

Timing: Key to Investment Success

A basic program for deciding when and how much to invest in common stocks and bonds

• Predicting the stock market's next move is called "little more than a gamble" by a Harvard professor of finance. As understatements go, this is pretty good. The Cowles Commission for Research in Economics found that of ninety predictions by one highly regarded forecaster, forty-five were right and forty-five wrong. The 7,500 recommendations made by sixteen financial services did less well than the average of all common stocks.

If you can't beat the market by forecasting, how *can* you hit on an investment program that will produce reasonable income and reasonable profit without unusual risks? Simply by setting up an investment pattern based on the one thing you're sure of: that common stock prices will continue to swing up and down.

One basis for such a pattern is known as formula timing. Formula timing is no panacea, but in the long run it almost always produces better results than forecasting. The idea is to capitalize on market fluctuations while still keeping your income fairly stable. You turn this trick by adopting a systematic plan that compels you—strange as it may seem—to sell stocks and buy bonds as the market rises, to sell bonds and convert the cash into stocks as the market drops.

Here's how it works:

Suppose you decide that a fifty-fifty ratio between volatile securities (usually active stocks) and defensive securities (usually good grade bonds) is about right for your circumstances. You start with, say, $10,000 capital, putting half in bonds and half in stocks. You

---

**This is the second article in a series by H. G. Carpenter of W. E. Burnet & Co., New York. Mr. Carpenter has been favorably known to investors for many years through his books, "A Successful Investor's Letters to His Son" (one of the most popular investment guides ever written), "Investment Timing by Formula Plans," "Investment Peace of Mind," "This is Investment* Management," *etc.*

make up your mind to restore that fifty-fifty ratio every six months. Here's what happens:

The market goes up and at the end of six months you hold, say, $5,500 in stocks and $5,300 in bonds. You adjust back to fifty-fifty: $5,400 of each. The market rises a few more points, then drops. After six months you hold $5,100 in stocks and $5,300 in bonds. Again you even up by selling bonds and buying stocks to give you $5,200 of each. Then the market rises. After another six months you end up with $5,700 in stocks, $5,300 in bonds. You balance your holdings at $5,500 each and then go on.

Like all programs based on formula timing, this one eliminates frantic attempts to forecast when the market will reach top or bottom—attempts which nearly always end in missing the boat. It demands only unruffled patience to sit tight while the stocks you have just sold go up, or those you have just bought go down. You know that your turn will come, and that using a prearranged pattern will produce better results than jumping nervously in and out of the market.

The example I've given is the simplest type of formula timing there is. Refinements make it more profitable. You can, for example, vary your ratio of stocks to bonds as the market changes. You pick some point on a standard index of stock prices—the Dow Jones Industrial Average, for instance—as your


tempering the cycle...
In the absence of organic pathology in various aberrations of the menses, Ergoapiol (Smith) with Savin often provides desirable symptomatic relief.
For this reason, many physicians prefer Ergoapiol (Smith) with Savin—a preparation containing all the alkaloids of ergot (prepared by hydro-alcoholic extraction), plus oil of savin and apiol. Besides inducing pelvic hyperemia, Ergoapiol (Smith) with Savin exerts a sustained tonic action on uterine musculature, as well as a hemostatic effect.
INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.
GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.
HOW SUPPLIED: In ethical packages of 20 capsules each, on a physician's prescription only.
May we forward your copy of the new 20-page brochure, "Menstrual Disorders—Their Significance and Symptomatic Treatment"?
MARTIN H. SMITH COMPANY
150 Lafayette Street • New York 13, N. Y.
ERGOAPIOL (SMITH) WITH SAVIN

base. You work out a schedule for altering your stocks-to-bonds ratio as the index moves above or below that base. As in the first example, such a schedule is designed to force you to sell stocks while prices are still high, to buy them while prices are still low.

Though programs based on formula timing vary widely, the principle stays the same. That principle is to cope with impatience by making all the decisions in advance, by leaving nothing to hunches or tips. Because such an investment plan keeps holdings adjusted to suit exact needs, it is popular with large investors like the Yale University Endowment Fund and the Vassar College Fund. Its use is being recommended more and more to smaller investors, who derive even greater protection from it.

Whether you work out a timing formula with a broker or on your own, check first to see how it would have worked in the past. Test it over a period long enough to include both rises and falls.

Timing is by far the most vital part of investment management. Important as it is to select industries and companies that will do better than the market as a whole, such selection is of little avail when the whole market drops. Then they all go down.

Your only protection in serious declines is to be holding a sharply reduced percentage of common stocks. A program based on formula timing will help you to do just that. —H. G. CARPENTER

Remarkable results in dysmenorrhea

In a clinical study extending over a period of a year, Long* used Edrisal as the sole medication in treating 630 employees for dysmenorrhea. Results were dramatic. He concluded, "We use it [Edrisal] with the knowledge that nine out of ten sufferers will get the relief they seek."

Edrisal combines the recognized analgesics—acetylsalicylic acid and phenacetin—with the unique anti-depressant, Benzedrine Sulfate. Consequently, it not only relieves the pain during the menstrual period, but also combats the accompanying psychic depression.

Best results are usually obtained with a dosage of *two* tablets, repeated every three hours, if necessary.

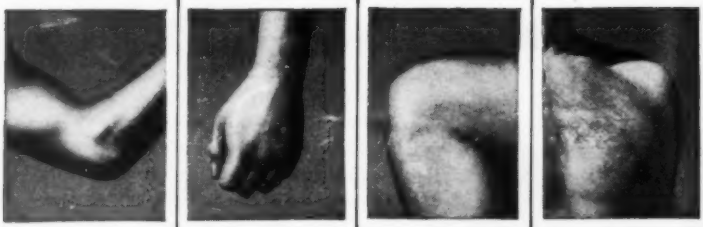
*Long, C.-F., M.D.: Edrisal in the Management of Dysmenorrhea, Indust. Med. *15*:679 (Dec.) 1946. Indust. Nurs. *5*:23 (Dec.) 1946.

Edrisal

highly effective in the relief of pain

Smith, Kline & French Laboratories
Philadelphia

Beyond the reach of human fingers



Beneficial effects may be exerted, not just locally but systemically, "beyond the reach of human fingers" in such conditions as arthritis, myositis, muscle sprains, bursitis and arthralgia. That systemic as well as local effects may be achieved by such preparations as Baume Bengué was conclusively demonstrated by the fundamental work of Moncorps, Kionka, Hanzlik, Brown and Scott.

LOCALLY—*at the site of discomfort analgesic relief and a beneficial hyperemia may be readily induced.*

SYSTEMICALLY—*the salicylate absorption promoted by Baume Bengué's methyl salicylate concentration produces systemic effects to reinforce other indicated therapeutic measures.*

Baume Bengué provides 19.7% *methyl salicylate,* 14.4% *menthol in a specially prepared lanolin base.*

Baume Bengué ANALGÉSIQUE

THOS. LEEMING & CO., INC., 155 E. 44th ST., NEW YORK 17

When Laymen Ask About New Hospitals

Let this handy catechism on the Hill-Burton program help shape your answers

• "What does the Hill-Burton Act mean to *my* community?"

More and more men and women are posing questions on how their home towns can tap the $375 million in Federal funds ticketed for new hospital construction between now and 1952. Physicians are often on the receiving end of such queries; but many of them have found the answers aren't easy to put in simple terms.

To guide you through the ins and outs of the new program, the Public Health Service has crystallized some of the answers most frequently sought. Here are the key queries you're likely to hear, plus the replies formulated by the PHS:

Q. "How will my community fit into the State Hospital Construction Program?"

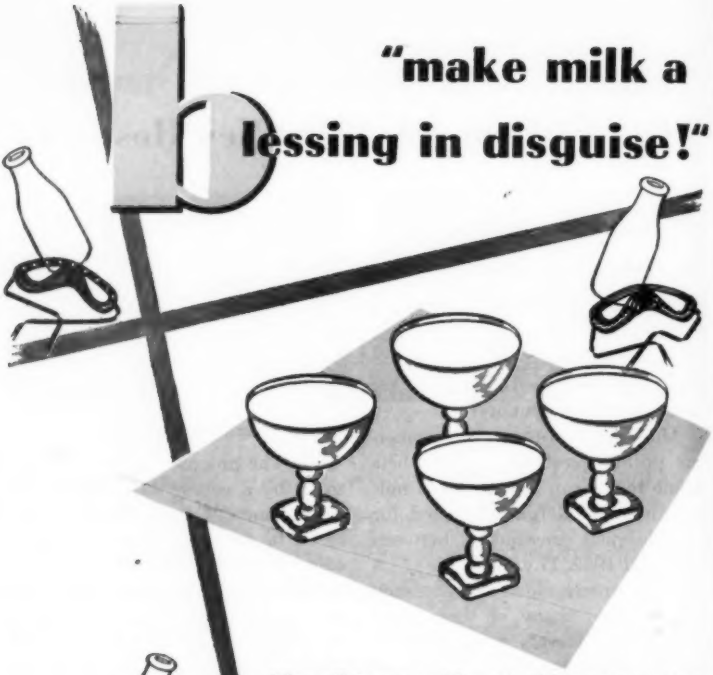
A. The location of new facilities will be determined by the actual needs of all other communities in the state. Since the amount of money authorized by the act is not enough to build all the needed hospitals and health centers, those communities with the most urgent need will come first. Each dollar of Federal money must be met by two dollars of state and local funds.

Q. "What are the requirements my community must meet?"

A. The proposed hospital, sponsored by a community, church, or other nonprofit group, must be located in an area of need as indicated by the state survey. In addition, the applicant must show that there will be enough money to meet its share of the construction costs and enough additional funds to maintain and operate the hospital when completed. There are also requirements concerning the specific plans for the building and state standards for maintenance and operation of the finished hospital.

Q. "What kind of hospitals can be built under the hospital construction program?"

A. General, mental, tuberculosis, and chronic disease hospitals and health centers. But tuberculosis and mental hospitals are usually large, publicly owned institutions; problems relating to these are not



"make milk a blessing in disguise!"

When milk is an essential nutritional factor (as in infancy, early childhood, pregnancy, gastro-intestinal and post-operative conditions), and yet it cannot—or will not—be taken by the patient . . . try "dressing up" this dietary "must", with the aid of "Junket" Brand Rennet Powder or Tablets. They make uncooked milk a true blessing in disguise by transforming it (easily and quickly) into appealing, flavorful rennet desserts. Rennet desserts are not only tempting to eye and palate; they retain the nutritional values of milk, yet are more easily and rapidly digested by virtue of the softer, finer, more flocculent curds produced in the stomach by rennin's enzymatic action. "Junket" Rennet Powder is available in six natural flavors, already sweetened; "Junket" Rennet Tablets are supplied unsweetened and unflavored (particularly valuable for diabetics).

"JUNKET" is the trade-mark of Chr. Hansen's Laboratory, Inc., for its rennet and other food products, and is registered in the United States and Canada.

"JUNKET" BRAND FOODS

Division of Chr. Hansen's Laboratory, Inc.

E-28 LITTLE FALLS, N. Y.

generally handled at the community level. So the chief concern of the community is the general hospital, which may or may not include beds for the care of chronic diseases.

Q. "How can our community determine its general hospital needs?"

A. A committee might be formed to study factors in the community which determine the amount of hospital service needed. The study group should consult the state agency, local hospital and health officials, and other authorities for much of the information needed.

Q. "How can we get a rough estimate of the number of general hospital beds needed in our community?"

A. In general, a ratio of 4½ beds per 1,000 population will give a fair estimate of the number of general hospital beds needed. Many communities will find after careful study that their particular needs are higher or lower than this figure. Communities in which a general hospital exists will need to subtract the number of hospital beds already available.

Q. "Are there any limits to the size of the hospital we should consider building?"

A. It is desirable that general hospitals range in size from 50 to 700 beds. Hospitals of over 700 beds tend to lose personal relations in their services. Hospitals of less than 50 beds generally cannot afford to provide the varied types of service needed.

Q. "If our community has no hospital and needs only a few beds, what shall we do?"

A. Consider the possibility of planning a community clinic with limited services for emergency treatment and obstetrical cases. More specialized services could be secured from larger hospitals nearby. Or the community might consider uniting its needs with one or more neighboring communities to build a hospital that would serve the entire area.

Q. "If we already have a hospital but need a few more beds, what then?"

A. A new wing or other addition might be built to provide the needed beds. If this isn't possible, a community might consider a community clinic to be operated in cooperation with the existing hospital.

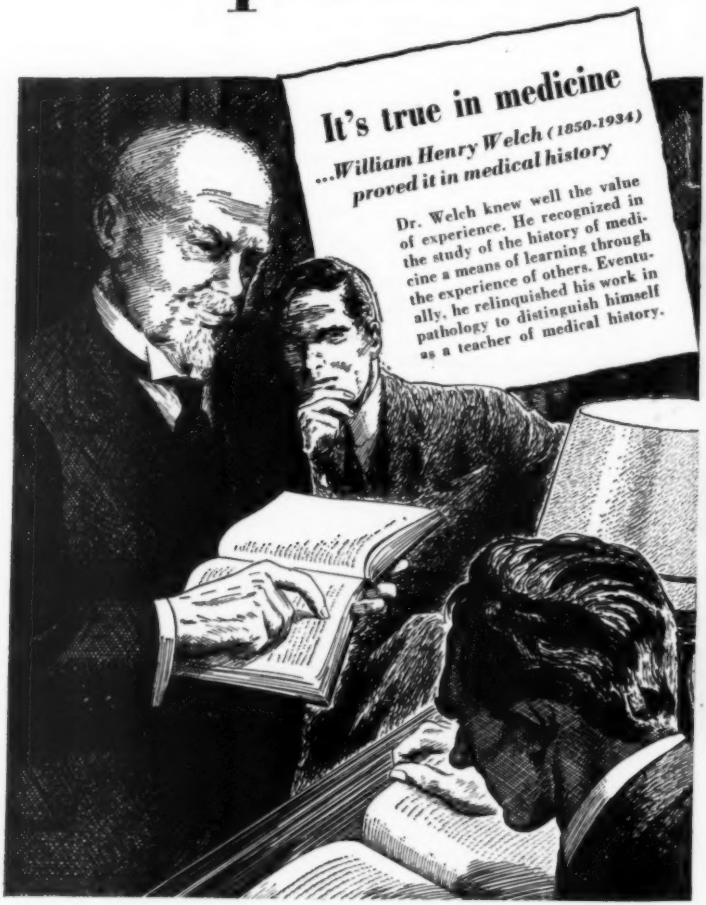
Q. "How much will it cost us to build and equip a new hospital?"

A. This cost will vary in different parts of the country but will probably range from $8,000 to $12,000 per bed.

Q. "How much will it cost us to operate a hospital?"

A. The annual budget may be

Experience is the



best teacher

It's true in cigarettes too!

MORE PEOPLE ARE SMOKING CAMELS THAN EVER BEFORE

YES, experience *is* the best teacher. And with millions of smokers who have tried different brands of cigarettes, Camels are the "choice of experience." Try Camels! See how the rich flavor of Camel's choice, properly aged and blended tobaccos pleases your taste. See if Camel's cool mildness isn't welcome to your throat. Let your own experience tell you why more people are smoking Camels than ever before.

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE

The makers of Camels are proud that so many doctors prefer Camels. In a nationwide survey by three independent research organizations, 113,597 doctors were asked to name the cigarette they smoked. More doctors named Camel than any other brand.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

estimated at one-third the total cost of constructing and equipping the hospital.

Q. "How many people will we need to run the hospital?"

A. In general, it takes 1.5 persons per patient per day to operate a hospital efficiently. This figure includes doctors, nurses, technicians, orderlies, cooks, dietitians, and all other personnel needed to care for the patient and maintain the hospital.

Q. "Will there be any problem in getting the trained personnel we need to run the hospital?"

A. There is a definite shortage of certain types of trained hospital personnel. Therefore, the community planning a new hospital should estimate carefully the size of staff needed. There is not much point in building a hospital, no matter how badly it is needed, if there are not enough people available to run it properly.

Q. "If our community is not eligible for federal funds but we have sufficient money on hand, should we go ahead on our own?"

A. Since the funds allotted by the hospital act will be far from sufficient to meet all the needs, independent construction should be undertaken to supplement the present program. The services of these hospitals should be coordinated with those of existing facilities and of any facilities scheduled for construction under the act.

'Benzedrine' Inhaler "recommends itself to the ambulatory patient and tends to make more certain the patient's use of the material."

Byrne, H. V.: New England J. Med. 20:1048.

between office treatments

Ease of application . . . convenience . . . wide margin of safety . . . effectiveness . . . all these make Benzedrine Inhaler, N.N.R., an excellent agent for use by patients between visits to your office.

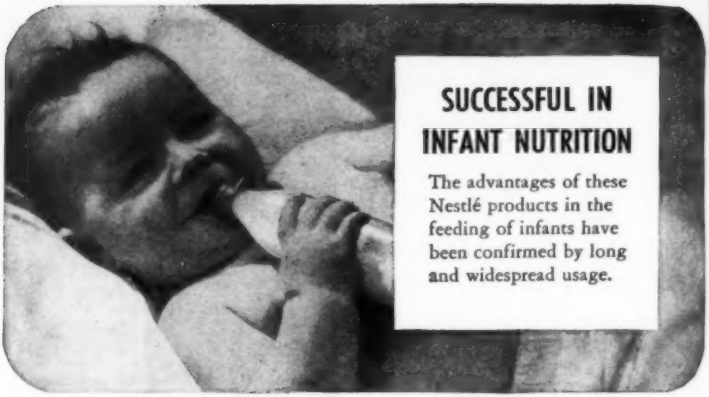
Providing shrinkage equal to, or greater than, that produced by ephedrine, and 17% more lasting, Benzedrine Inhaler affords rapid and prolonged relief of nasal congestion in head colds, allergic rhinitis and sinusitis. Smith, Kline & French Laboratories, Philadelphia

Benzedrine® Inhaler

a better means of nasal medication

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; menthol, 12.5 mg.; and aromatics.

®T.M. REG. U.S. PAT. OFF.



SUCCESSFUL IN INFANT NUTRITION

The advantages of these Nestlé products in the feeding of infants have been confirmed by long and widespread usage.

SPRAY DRIED

LACTOGEN

HOMOGENIZED
WHOLE COW'S MILK
Modified with
MILK FAT
LACTOSE

Reinforced with **IRON**

EVAPORATED

DEXTROGEN

HOMOGENIZED
WHOLE COW'S MILK
Modified with
DEXTRINS·MALTOSE
DEXTROSE

Reinforced with **IRON**

ACIDIFIED • SPRAY DRIED

PELARGON

HOMOGENIZED
WHOLE COW'S MILK
Modified with
GLUCOSE · SUCROSE
STARCH

Reinforced with { **IRON** **VITAMINS A B C & D** }

No advertising or feeding directions except to physicians

NESTLÉ'S
MILK PRODUCTS, INC.
155 East 44th Street
New York 17, N. Y.

Check coupon for literature and samples desired.

LACTOGEN ☐ DEXTROGEN ☐ PELARGON ☐

Dr. _____

Address _____

City _____ Zone _____ State _____

Get Tax Benefits from Your Gifts

Make up your annual list of contributions with your income tax return in mind

• Helping yourself while you help others is not hard to arrange under the Federal income tax laws. If you contribute to domestic, nonprofit organizations, such gifts can generally be lopped off your taxable income. But to get the best blend of giving and saving, you'll want to know some finer points on how to deduct your contributions.

Choosing gift recipients wisely is a first step. If you want your contribution to be deductible, it must go to a body in the U.S. or its possessions that is operated exclusively for religious, charitable, scientific, literary, or educational purposes. The body must be formally organized (on a nonprofit basis) as a corporation, trust, fund, or foundation.

Examples of allowable deductions are gifts to your church, your community chest, the American Red Cross, and to some fraternal orders. Contributions to national, state, and local governments "for exclusively public purposes" are also deductible. So are donations to the special fund authorized by Congress for vocational rehabilitation.

But your check to a political fund, lobbying organization, or any group whose earnings benefit a private person won't be allowed as a tax cut.

Under the wording of the tax statute, you probably won't get any tax benefit from contributions to charities outside the United States, no matter how commendable their purpose. Nor will donations made directly to private individuals or to unorganized groups help you on March 15. Gifts to medical associations are not deductible under this heading, but they can often be deducted as professional expenses.

Now consider the ceiling on gift deductions. It is pegged at 15 per cent of your adjusted gross income. Suppose your 1947 records show the following:

Professional income (net after expenses)	$7,500
Other income (salary, dividends, interest)..	500
Adjusted gross income..	$8,000
Contributions made during 1947	$2,000

[*Continued on* 148]

Since only 15 per cent of the $8,000 is deductible for gifts, you're allowed to deduct only $1,200 instead of the full $2,000.

Contributions are good tax deductions only in the year paid regardless of when pledged. If, for example, you signed a pledge in 1947 to contribute $200 to the community chest, and you paid the $200 early in 1948, that makes the deduction apply to your return for 1948, not for 1947.

Here's another tax-saving possibility: Suppose you hold a security that cost you $1,000 and is now worth $1,500. If you want to make a charitable gift of the latter amount, give the security itself. Should you sell the security for $1,500, you'd have to pay a tax on the $500 capital gain. Contributing the security itself costs you nothing in tax, gives you a charitable deduction of $1,500, and furnishes the charity with the full $1,500 worth.

On the other hand, if a security cost you $1,000 and has declined in value to $750, reverse the process. Sell the security and contribute the $750 cash proceeds to the charity. That gives you not only the gift deduction of $750 but also a capital loss deduction of $250.

Like every other important deduction, gifts require proof. Your cancelled checks are of paramount importance; when possible they should be supplemented by letters of acknowledgement from the recipients. —ALFRED J. CRONIN

Continue until weaning...

No substitute for mother's milk is more highly regarded than Similac for feeding the new born, twins, prematures, or infants that have suffered a digestive upset. Similac gives uniformly good results in these special cases simply *because it resembles breast milk so closely.* Normal babies thrive on it *for the same reason.*

This similarity to breast milk is definitely desirable—from birth until weaning.

M & R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D, and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

SIMILAC *Similar to breast milk*

6 basic advantages in wound healing–

CHLOROPHYLL THERAPY

1. Accelerates healing
2. Stimulates normal cell growth
3. Reduces scar formation
4. Controls superficial infection
5. Is nontoxic—bland and soothing
6. Deodorizes malodorous lesions

CHLORESIUM, the water-soluble chlorophyll derivative preparation, stands out in the field of wound healing in a completely unique position. A natural biogenic agent, it is absolutely nontoxic, bland and soothing—and of marked biological activity. It promptly accelerates normal cell regeneration, thus measurably hastening the healing process, provides symptomatic relief and deodorizes foul-smelling suppurative lesions.

Chloresium is widely used by leading clinicians, V. A. and private hospitals and many thousands of physicians. They report extremely favorable results in the treatment of wounds, burns, ulcers, dermatoses and upper respiratory conditions, especially in chronic, indolent cases.

If you have not used Chloresium, send the coupon below.

Chloresium

FREE—Send for sample!

Chloresium is ethically promoted. Available at all leading druggists.

CHLORESIUM SOLUTION (Plain)
2-oz. and 8-oz. bottles

CHLORESIUM OINTMENT
1-oz. tubes and 4-oz. jars

CHLORESIUM NASAL SOLUTION
½-oz. dropper bottles and 2-oz. and 8-oz. bottles.

Rystan Company, Inc.

SOLE LICENSEE—LAKELAND FOUNDATION

7 N. MacQuesten Pkway, Mt. Vernon, N.Y.

RYSTAN COMPANY, Inc., Dept. ME-1
7 N. MacQuesten Pkway, Mt. Vernon, N.Y.

Please send "Chlorophyll—Its Use in Medicine," and clinical sample of:

- ☐ Chloresium Solution (Plain)
- ☐ Chloresium Ointment
- ☐ Chloresium Nasal Solution

*Name*_____ *M.D.*

*Street*_____

*City*_____ *Zone*___ *State*

How Much Decentralization in a National Health Program?

Neither Taft nor Wagner bill said to provide the proper Federal-state balance of power

• A national health program needs enough Federal supervision to see that Federal funds aren't wasted, enough local control to assure that each state's individual problems are met. But just where do you draw the line?

That's one question that five members of a Senate subcommittee on health are currently tossing back and forth. If their present thoughts mirror those of the health experts who have aired their views on the matter, the consensus is this:

¶ The Wagner health bill, S.1320, makes a show of providing decentralized administration; but actually it would vest nearly all power in a Washington board.

¶ The Taft health bill, S.545, veers to the other extreme: It would hand over nearly all administrative power to the states, permit a minimum of effective guidance at the Federal level.

In groping for a middle road, the legislators have a raft of conflicting opinion to choose from. Some of it comes from within their own ranks. For example, Sen. James E. Murray (D., Mont.) believes that Washington control is as inevitable as death and taxes. Says the co-sponsor of the Wagner health bill:

"This country is now just a few theoretical steps behind the kind of economy they had in Germany before the war. Concentration of ownership in business has gone to such a degree that we have been compelled to introduce all sorts of compulsions." Practically every Washington bureau, he says, was established to police big business. "We've got a collectivized system in this country and you can't change it now."

But Senator Murray's frankness is not supported by some of his prize witnesses. Dr. Ernst P. Boas of the Physicians Forum says: "The Wagner health insurance bill spells out decentralization of administration in detail. Health benefits would be administered wherever possible by the states. Each would be given great latitude."

And Watson B. Miller, former Federal Security Administrator, believes that under the Wagner Bill,

"the role of the Federal administrative agency would be mainly to collect and allocate the funds, to determine the insured status of individuals, and to assure that basic standards are complied with. Thus, responsibility for the operation of the program is decentralized to local authorities."

All of which fails to convince Sen. Forrest C. Donnell (R., Mo.), a majority member of the health subcommittee, that Wagner Bill decentralization is anything but window dressing. "Under S.1320 we would have this set-up," he points out: "a National Health Insurance Board of five members (only two of whom have to be doctors) and a National Advisory Medical Policy Council of seventeen members, one of whom is chairman of the insurance board. The Federal Security Administrator appoints the other sixteen. So isn't it true that the ultimate decision rests with the Federal authority?"

The FSA chief also looms large in another section of the Wagner Bill quoted by Senator Donnell: "One sentence says, 'All functions of the board shall be administered by the board under the direction and supervision of the Federal Security Administrator.' This certainly vests all authority not in the board, not in the advisory council, not in the states, but in one man who does not have to be a doctor."

This interpretation seems to fit Co-Sponsor Murray's collectivization thesis. But neither Senator

because

children

and

adolescents

grow

so rapidly

their requirements are increased for the B Complex vitamins which Pentaplex supplies in a delightfully palatable and easily tolerated elixir. Your young patients will *like* to take Pentaplex.

Eskay's **Pentaplex**

makes

B Complex

therapy

palatable

Smith, Kline & French Laboratories, Philadelphia.

Donnell nor a number of others in Government agree with the Montana legislator that administration by Federal bureau is inevitable. One dissenter is David E. Lilienthal, chairman of the Atomic Energy Commission. Says Mr. Lilienthal:

"Experts in administration are trying to persuade the American people that centralized Big Government is inevitable . . . It is obvious that many problems that once could be dealt with locally now require a national policy . . . But it does not follow that the administration of that policy must be on a nation-wide basis.

"We must rid ourselves of the notion that a new staff, with every member paid out of the Federal Treasury, has to administer every detail of each new Federal law. Our problem is to divorce the two ideas of authority and administration of authority. The distinction is one that apologists for Big Government persistently overlook."

To some health experts, the Taft Bill fits the Lilienthal principle neatly. Says Father Alphonse M. Schwitalla of the Catholic Hospital Association: "S.545 gives full consideration to local differences and individual rights. It facilitates liberalized programs that are exactly suited to the various states and localities."

But Doctor Boas believes the Taft Bill carries decentralization too far. He says: "The health services in the forty-eight states vary tre-

RIASOL to the rescue in PSORIASIS!

RIASOL frequently comes to the rescue of the psoriatic patient who needs prompt and effective help. Thousands of physicians, and their appreciative patients, testify to the advantages of a RIASOL prescription.

Outstanding among the clinical results with this distinctive formula are:

1. **Usually effective and rapid clearing of ugly lesions.**
2. **Prompter fading and gradual disappearance of the disfiguring patches in most cases.**
3. **Fewer recurrences in a majority of instances.**
4. **Patient acceptance, cooperation and satisfaction.**

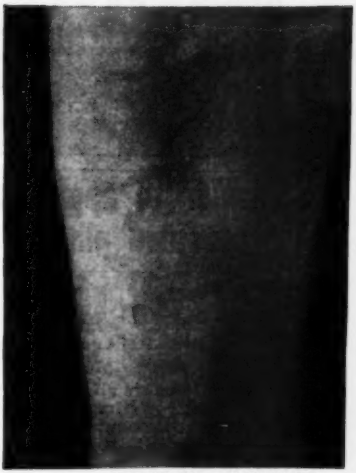
RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages necessary. After a week, adjust to patient's progress.

RIASOL is ethically promoted only. Supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

MAIL COUPON TODAY—
PROVE RIASOL YOURSELF

BEFORE Use of RIASOL



AFTER Use of RIASOL

SHIELD LABORATORIES ME-2-
8751 Grand River Ave., Detroit 4, Mich.

Please send me professional literature and generous clinical package of RIASO

.....M.D.....Stre

City.....Zone.....State.....

Druggist.....Address.....

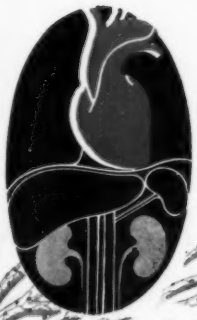
RIASOL FOR PSORIASIS

mendously in efficiency and quality. When such large sums of Federal money are given as grants-in-aid, there should be principles to insure high standards." Because the Taft Bill sets up no Federal standards, Doctor Boas believes, "the inevitable result would be disorganized and inferior medical services."

The AFL's Nelson H. Cruikshank also takes a dim view of state administration of a national health program. "We have never been very successful in so-called experiments by states," he says. "States always lag behind the Federal Government. We had unemployment compensation first in 1850. In 1933—after eighty-three years—only one state had taken the opportunity to experiment."

But the prevailing Congressional view on health programs is put into words by Sen. H. Alexander Smith (R., N.J.), chairman of the Senate's subcommittee on health: "Before we can have national coverage at one fell swoop, we must experiment on a smaller scale. I believe that we can profit by trial and error in the states. By that process we will get a better solution to our health problems than by having a few theorists sit down and write a complete blueprint for the whole country."

The problem, then, is to combine trial and error in the states with enough Federal supervision to avoid the squandering of public funds. That's the blend Senatorial health experts will try to achieve during the current session of Congress. —EDWARD E. RYAN



one and one-half acres

MERCUHYDRIN®

The fluid that inundates the tissues during congestive heart failure may pass through approximately one and one-half acres of capillary wall. Following an intramuscular or intravenous injection of MERCUHYDRIN, edema fluid comprised of water and salts, chiefly sodium chloride, is mobilized back through the one and one-half acres of the capillary bed and is eliminated through the kidneys. The diuresis obtained with MERCUHYDRIN benefits not only the patient with palpable edema, but also the patient subject to cardiac decompensation. "The effect on dyspnea in these cases of left-sided failure is probably largely a result of diminution in pulmonary edema, even though the latter is clinically occult."*

The management of cardiac decompensation is greatly facilitated and the comfort and well being of the patient is greatly increased by administration of

MERCUHYDRIN *early*, concurrently with digitalization

MERCUHYDRIN in a systematic schedule of *repeated* doses as maintenance therapy

MERCUHYDRIN by *intramuscular* injection, well tolerated locally and systemically, and affording highly effective diuresis

MERCUHYDRIN (meralluride sodium) is available in 1 cc. and 2 cc. ampuls

*Fishberg, A. M.: Heart Failure, Lea and Febiger, Phila., 1946, p. 733.

Lakeside Laboratories, INC. MILWAUKEE 1, WISCONSIN

Rx for Fee Disputes: Arbitration

How one successful medical society plan is resolving its patients' complaints

● By providing for fee arbitration when patients complain of excessive charges, the doctors of Wayne County, Mich., have recognized and acted on one of the basic public relations problems facing medicine today. Their technique for settling disputed fees has allowed many a patient to let off steam. In the process it has greatly increased good will for the profession.

By the fall of 1946, half the complaints received at Wayne County Medical Society headquarters concerned fees. The society decided it was high time to take action. It set up a brand-new committee on fee arbitration, possessing no disciplinary powers and having no connection with the society's ethics committee. Its only function was to talk out the question of the disputed fee and encourage an amicable settlement.

Today this Mediation Committee consists of five prominent physicians who study each complaint from three angles: the amount of service rendered, the responsibility assumed by the doctor, and the patient's ability to pay.

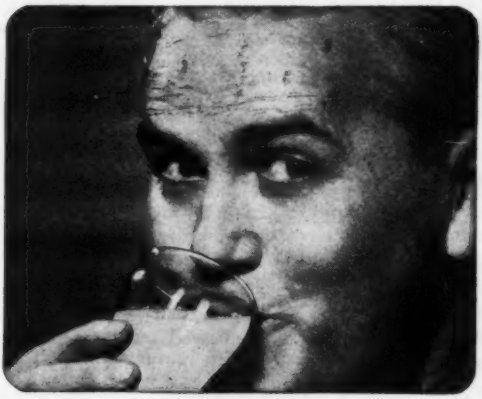
The fifteen complaints handled by the committee over a recent six-month period included nine relating to type of service rendered, *e.g.*, incomplete physical examinations, unsuccessful operations, hurried office calls, or alleged discourtesy. Four complaints were due to the patient's misunderstanding of the responsibility assumed by the physician (these involved fees for hospital calls when the operation was performed by another physician, or fees charged for services not rendered by the physician personally, as in obstetrical work). In two cases the fees charged were modest but beyond the patient's ability to pay.

In six of the cases it arbitrated, the committee ruled that the fee was not out of line and notified the patient accordingly. In five cases, the bill was reduced. In one case, it was canceled. Each complaint was considered individually; the committee tried in no way to encourage or to maintain a fixed fee schedule.

Following is the procedure Wayne County's committee has

"Good Medicine"

... and a pleasant prescription for better health!



Today, good nutrition is good therapy, and high on the list of nutritionally valuable foods are the citrus fruits. Their tempting and refreshing forms, containing a veritable storehouse of essential nutrients,* soundly recommend their routine inclusion in the patient's dietary.

Their content of natural vitamin C—so helpful in the restoration of tissue health and vigor[4]—is extraordinarily high. Their yield of easily-assimilated, rich fruit sugars[2] is excellent; and by improving calcium retention,[1] they quicken bone and blood building. The base-forming properties[2] of the citrus fruits exert a highly beneficial effect throughout the alimentary tract[1] and encourage systemic normality. And their refreshing, tart goodness is always a stimulus to flagging appetites.[1]

Florida citrus fruits and juices in the diet (either canned or fresh) —for growth, pregnancy, lactation, infant feeding, illness or convalescence—is always a "good prescription for good health"!

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

**Citrus fruits are among the richest known sources of vitamin C; they also contain vitamins A, B, G and P, and other nutritional factors such as iron, calcium, citrates, citric acid and readily assimilable fruit sugars.*

References

1. Bridges, M. A.: Dietetics for the Clinician. Lea & Febiger, 4th ed., 1941.
2. McLester, J. S.: Nutrition and Diet in Health and Disease. W. B. Saunders Co., 4th ed., 1944.
3. MacLeod, G. and Taylor, C. M.: Rose's Foundation of Nutrition, The Macmillan Co., 4th ed., 1944.
4. Sherman, H. C.: Chemistry of Food and Nutrition, The Macmillan Co., 7th ed., 1946.

FLORIDA

Oranges • Grapefruit • Tangerines • Limes

used successfully in settling fee disputes:

On receipt of a routine fee complaint, the committee sends a copy to the doctor. With it goes a letter stating that, though the committee has no authority to adjust fees charged by an individual doctor, the Wayne County Medical Society considers equitable settlement of such grievances a foundation stone of good public relations; the committee is therefore calling this to his attention and asking for his suggestion on how the complaint should be handled.

When an explanation comes in from the doctor, the complaint is discussed by the committee. If its members feel that the fee charged is reasonable in view of the services rendered and the responsibility assumed, the patient is notified to that effect.

But if the committee decides that the patient has a justifiable complaint, the doctor is urged to make an adjustment. The patient is told to contact his doctor, then to inform the committee if a satisfactory settlement is not reached.

In cases where the fee is obviously too high, the doctor is invited to come before the committee to discuss his bill. The committee has found the medical rank and file cooperative wherever its objectives are explained and understood. Even though a doctor may not feel that his fee *is* out of line, he is often willing to reduce it for the sake of an amicable settlement.

As for the patient, the committee has discovered that many complaints stem from lack of knowledge. Often a settlement can be reached merely by explanation. Even when no financial adjustment is made, having the complaint investigated creates better feeling.

As a result of these findings, the committee is convinced that only a small percentage of medical men charge exorbitant fees. If this small group can be shown the effect of these charges on the profession's reputation, Wayne County doctors feel an important contribution will have been made to better public relations. —ARTHUR MYER

FOOD SUPPLIES just now—and in the immediate future—are sufficient to assure optimum diets for only a fraction of the world's billions.

Nutritional science can help in this period by determining, as accurately as possible, the minimum requirements of food elements . . . by answering the question: How can limited food production be made to benefit the greatest number?

Carbohydrates have always been the most abundant of foods. They are the only class of foodstuffs available in sufficient quantity to provide needed calories at prices people can afford. They must, therefore, comprise the major part of the diet.

There are also compelling physiologic reasons for their place in the diet. Ample carbohydrate spares proteins, preventing waste of the essential amino acids. And its role in the utilization of fats is well recognized. A fuller understanding of the functions of carbohydrate in human metabolism is therefore an imperative concern of research.

To determine objectively the dietary role of sugar—one of the great carbohydrates—Sugar Research Foundation has, since 1943, been supporting research by qualified independent investigators. A summary of these projects—their purposes and findings—will be sent on request to any interested individual or institution.

SUGAR RESEARCH FOUNDATION

A NON-PROFIT INSTITUTION

52 Wall Street, New York 5, N. Y.

Psychiatric Care [*Cont'd from* 75]

usually fit his appointments to patients' time-tables better than the surgeon since he doesn't have to anticipate emergency calls or reserve time for hospital visits.

You'll often hear this response from patients: "I'm not neurotic. I don't just imagine these pains. I really have them." Nothing arouses more resentment than a doctor's implication that the patient's symptoms are imaginary. A safe answer: "I know your pains are real. But examination shows you have no structural disease in these organs. Your pains are due to nervous tension. It's precisely because there is no disease of the organs themselves that I expect you to get well."

This rejoinder serves two purposes: It hooks up the need for psychiatric care with the physical symptoms. And it implies a favorable prognosis.

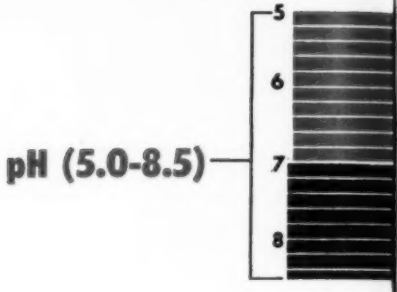
When you bring up the subject of psychiatry, self-assured patients may object: "Why, I'm not nervous. I don't have a nerve in my body." The most adroit way of meeting this retort is: "That's just it. If you felt nervous and showed it by jittery restlessness, then that would drain out the nervousness. Instead, without knowing it, you are holding back. That's what makes your heart pound (or causes muscles cramps, or pours acid into your stomach, or whatever the psychosomatic explanation). A psychiatrist will sit down with you and work out all these emotional factors."

Another common line of resistance is based on a sense of shame: "If I'm seen walking into a psychiatrist's office, my family and friends will think I'm wacky." That's the family doctor's opening to explain that "All intelligent people today accept the role of psychiatry. Besides, the specialist doesn't have any distinguishing mark on his sign—just a plain M.D. The only people who know he is a specialist in nervous disorders are his other patients."

In spite of all your reasoning, some patients will still plead for medicine to make their symptoms disappear. One way of meeting this is to say: "I can do that easily enough. But you're too smart to be satisfied with some pain-killing drug. Nothing to date has helped you. Why not get to the bottom of the trouble once and for all?"

It is to be remembered, too, that psychiatrists are available for consultation just as other specialists are. They know that in some cases the family doctor can get further with the patient than the specialist. The latter's main function, then, is to give practical tips on handling each kind of patient. The referring physician should expect the psychiatrist to supply regular reports on each patient referred. These reports will throw a lot of light on what makes people act the way they do. —CARL L. KLINE, M.D.

pH.....; t

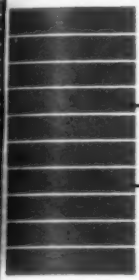


infected vagina

Based on knowledge of the physiology of the vagina, rational therapy of vaginal infection should include not only the destruction of the offending organisms but also the reestablishment of the normal vaginal processes.

FLORAQUIN

—a product of Searle Research—offers an effective therapeutic and restorative agent in combating vaginal pathology. It provides the potent protozoacide, Diodoquin-Searle, which inhibits and destroys pathogenic organisms; Floraquin also supplies acidulated lactose and dextrose for absorption and conversion into mucosal glycogen and for the restoration of a normal protective vaginal pH.



pH (3.8-4.4)

normal vagina

FLORAQUIN
POWDER
—for office insufflation.

FLORAQUIN
TABLETS
—for home use.

Floraquin and Diodoquin are the registered trademarks of G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

How Physician-Backed Prepay Plans Can Meet U.S. Health Needs

Public Health Service appraisal lauds doctors' plans but lists eleven sweeping changes that are needed

• Voluntary prepayment plans are "an important contribution" to national health and security. The physicians and laymen behind them "have every reason to be proud of their accomplishments." But the plans are *not* making an all-out effort. Until they do, voluntary health insurance will remain in second gear.

That's the verdict of the U.S. Public Health Service. For the past three years it has been taking a long look at the organization, operation, and scope of America's voluntary plans. Its final report* finds much to praise, much to criticize. But wherever the PHS finds gaps, it suggests ways in which they can be filled.

This sweeping evaluation of medicine's efforts to extend prepaid medical care bears the signature of Health Economist Louis S. Reed. In a book published ten years ago, Reed argued hard for "a system of state medicine" with all medical service given by salaried physicians. But the current study is notable for its objectivity. It gives credit where credit is due. For example:

"Hospital and medical plans are beneficial for the subscribers, the hospitals, the medical profession, and the general public. People obtain care who otherwise might go without, and they tend to obtain care more promptly.

"The plans facilitate collection of charges. They enable hospitals and physicians to obtain fair remuneration from some subscriber-patients who, without the plan, would be able to pay little or nothing. They tend to increase and stabilize the incomes of hospitals and the profession."

But the voluntary movement will not become fully effective, says the PHS economist, until it provides *all* medical and hospital services on a uniform, nation-wide basis. Local prepay plans, he believes, must surrender some of their autonomy to a national organization, some of their

*"Blue Cross and Medical Service Plans," by Louis S. Reed, Ph.D. 323 pages. Federal Security Agency, U.S. Public Health Service 1947.

* HANDITIP *

Spill-Proof

An iodine-stained bag taught me this trick: I stuff a small, screw-top bottle full of absorbent cotton, then saturate it with iodine. When I have to use some, I press a cotton-tipped applicator into the bottle until the tip has enough iodine on it for swabbing. —M.D., IOWA

* * *

reserves to a national pool. That way, he says, the public will be assured of getting what it pays for.

Exactly how can prepayment plans serve the public more effectively? Here's the gist of the major PHS recommendations:

Broaden scope of benefits: The time has come for prepay plans to abandon restricted service and to offer comprehensive coverage. With few exceptions, the medical plans now cover only about one-third of the total cost of physicians' services; but the public wants complete coverage; and only through complete coverage can it obtain adequate care. Restricted contracts sometimes lead to hospitalization of patients who could be treated just as well—and with greater economy—as ambulant cases.

So too with hospital plans. Some schedules provide virtually complete protection; others are full of gaps. Blue Cross will achieve full usefulness when it pays *all* hospital costs, including special service costs, over longer periods. The cost of special nursing, for instance, may be greater than all other hospital costs during a serious illness.

Pay subscribers in service, not in cash: The indemnity method cannot provide complete protection, since neither doctor nor hospital is obliged to accept the cash allowance as full payment. Medical plans would be more useful if they extended service benefits to all subscribers regardless of income.

Reduce waiting periods: Requiring infants to reach a specified age before extending benefits to them is undesirable. Many plans have recognized this and now cover them from the day of birth. Waiting periods for maternity care can also be eliminated in group enrollment, although they may still be necessary in individual subscriptions.

Reduce exclusions of pre-existing conditions: Such exclusions are still necessary under individual enrollment but not under group enrollment. Some plans probably spend more money trying to find and reject such conditions than they would in caring for them. Putting

another of its several advantages:

THE WATER SOLUBILITY of all components of Furacin Soluble Dressing enables it to dissolve in blood, pus and serum, facilitating penetration to all parts of the lesion; permits its ready removal by irrigation with sterile saline.

Indications:

Infected surface wounds, or for the prevention of such infections
Infections of second and third degree burns
Carbuncles and abscesses after surgical intervention
Infected varicose ulcers
Infected superficial ulcers of diabetics
Impetigo of infants and adults
Treatment of skin-graft sites
Osteomyelitis associated with compound fractures
Secondary infections of dermatophytoses

EATON Inc.
NORWICH, NEW YORK

an end to this sort of restriction would do a lot for the plans' public relations.

Assume responsibility for quality of care: The voluntary plan is more than a device for prepaying costs; it should also assure good care. To that end, it should require improvement in the services it finances. Medical plans, for instance, would increase their usefulness by establishing diagnostic centers, aiding in the development of group practice.

Blue Cross, too, should see that subscribers get progressively better care. A plan that pays hospitals one-third to one-half of their incomes should be strong enough to prod them into improvement. One way to accomplish this might be to pay higher rates to institutions that give superior and more comprehensive care.

Provide cut-rate contracts for low-income groups: Blue Cross, for instance, could offer low-cost, ward-accommodation contracts, with hospitals guaranteeing free choice of doctors. Without free choice, such programs have failed. Ward subscribers found they could not have their own doctors when hospitalized. They were then worse off than indigent patients: They were paying for something they could easily obtain without charge.

Give the public a greater voice in prepay plan control: When physicians run their own plans, they determine how much they are to be paid for their services. The term "nonprofit" then becomes contradictory. If a plan's primary purpose is to serve the public, the public should have a substantial share in its control, probably a dominating one.

That is not practicable when a plan is getting its start. Its major asset is then the support of doctors, so control by the profession is appropriate. But when a plan builds up a substantial cash reserve (which belongs to the public), at least an equal share of control should be given to laymen.

Establish a national pool of reserves: This would insure collective and individual security. It would also permit prepay plans to earmark a smaller proportion of their income for reserves, since they could fall back on the national pool in an emergency.

Under this arrangement, each plan would contribute periodically

* HANDITIP *

Seating Plan

When I redecorated my reception room, I substituted a two-seater couch for my old three-cushion model. My patients aren't strangers to me, but they are to each other. The middle-man on the old couch was usually both uncomfortable and ill at ease. —M.D., NEW YORK

* * *

a definite fraction of its income to the central reserve. Its books would be audited frequently by the national organization, which would have the power to prescribe minimum local reserves. If, in a pinch, the national fund lent money to a plan, it would assume financial control of that plan until the loan was repaid.

The Blue Cross could—and should—set up such a pool at once. Medical plans are not yet ready for the step. Until they are, they must (a) set up adequate reserves or (b) require doctors to guarantee their services or (c) do both. Until a reserve is established, doctors *must* guarantee service.

Step up efficiency of slow-growing plans: Certain hospital and medical plans are making poor progress. In each case, the diagnosis indicates the treatment required. A number of them lag because of indifferent support from medical men. Others lack aggressive, alert leadership. Some offer contracts that are so restricted or complicated they cannot be sold. Still other plans try to build reserves too quickly by asking exorbitant premiums.

Merge local plans: In many instances, plans with poor enrollment records have been serving areas too small in size to permit efficient operation. In such cases, the competition between two state-wide plans results in increasingly high administrative costs.

If a state has a number of prepay plans, a merger of at least some of them should be considered. Often the public would be better served by a single, state-wide plan. The advantages of local administration are fading. They are being offset by increased disadvantages of multiple operation.

The fortunes of medical and hospital plans are inevitably bound together. Neither can achieve maximum success without the other. Those that operate in the same area should eventually become a single unit. Meantime, they should be jointly administered by a single staff under one executive officer.

Strengthen national coordination: Interstate employers and industry-wide unions prefer to deal with one national organization. Only in this way can they obtain uniformity in benefits, rates, enrollment procedures, and billing.

That means the plans must develop a much stronger national agency. They must also be prepared to yield some portion of their autonomy to it. As a mere association of sovereign, independent plans they cannot meet the full challenge of prepayment. —ALTON S. COLE

This is the type of advertising Beech-Nut is running in newspapers and magazines to reach mothers

Atom War [*Continued from* 58]

that planning includes sound medical advice; (c) to recruit the medical brains needed; (d) to help organize both lay and professional education.

With one exception, all members of the council served in the armed forces. They are: Drs. James Sargent of Milwaukee; Richard L. Meiling of Columbus; Harold Diehl of Minneapolis; Harold C. Lueth of Omaha; Perrin Long of Baltimore; Stafford L. Warren of Los Angeles; W. McKendree Craig of Rochester (Minn.); Edward L. Bortz of Philadelphia; and George F. Lull of Chicago.

The council has conferred with the Surgeons General of the Army and Navy and with representatives of the PHS and Selective Service. Already it has been deluged by inquiries from medical associations and medical schools asking what they can do. But no answer will be ready until the council has decided how it will tackle its objectives.

The situation today is this: We have no master plan for medical care of civilians in World War III. It will probably take two years to block it out, two more to get organized. Even now, we have no assurance the wheels will turn as fast as they should.

But for the moment, about all the individual doctor can do is alert his friends—both lay and professional—to the grim consequences of delays.

—J. F. MARTIN

Here is why

B-D NEEDLES

are *Professionally Preferred*

All B-D Stainless Steel Needles fit perfectly on B-D glass syringes and lock into the tips of Yale B-D Lok-Syringes.

Designed for easy grip and quick handling. Will not roll. Stamped with name on one side, gauge number on other.

Needle withstands more than twice the reverse bends required by government standards. Juncture of hub and cannula alcohol tested under pressure against leakage.

Hyper-chrome stainless steel cannula, rustless *throughout*. Resists iodine, salts and most acids.

Longer tapered, stronger reinforced Point. Cutting edges shorter and sharper. Result, an extremely keen, smooth point for easy and practically painless penetration.

Yale B-D Lok-Needles are available in both

REGULAR and HUBER POINT

— at the same price

See your **1948 B-D Blotter** for AHA Needle Standardization List

B-D PRODUCTS

Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

How to Make Better Use of Your Medical Library

Whether your aim is light browsing or heavy research, these cues will help you

● The pearls of wisdom let drop by the country's best medical teachers can nearly always be found in print—if you know where to look for them. Buried on the shelves of the medical library is the help you need in understanding a puzzling case, in boning up for a board examination, or in preparing a scientific article.

Medical libraries are to be found nowadays not only in academies of medicine and medical schools and hospitals but also in some county and state medical society offices, in the larger private groups, and as adjuncts to some general public libraries. Whether you're in Chicago or Snohomish, the question on your mind as you stride through the entrance is: "Where do I find what I want?"

Consider motive number one: help wanted for a puzzling case. To put your finger on the cause of a strange symptom, start by examining one of the standard textbooks on diagnosis. Suppose, for example, that your patient has one isolated symptom such as weakness of the arm. You want some briefing on the possible causes of this monoplegia. Begin by looking up the symptom in a book like French's "Index of Differential Diagnosis" or Barton and Yater's "Symptom Diagnosis." Listed there are a dozen conditions in which monoplegia may be a symptom. Or turn to a good textbook on neurology, since all forms of paralysis are touched on in such a volume.

The Latest Thing

Perhaps you'd like help next in planning treatment. An epileptic patient, we'll say, has not responded to the usual barbiturates. You recall that some new drugs are being used in such cases, but you don't remember the names, dosages, or contra-indications. When the question is one of finding something *new* in medicine, the medical journals are likely to be your best bet. Practically all major medical discoveries of the past half-century were announced in journals long before they were printed in books. But a glance at the periodical

shelves of a large medical library may discourage you. You see half a dozen journals on each specialty, plus forty or fifty state and local periodicals. Leafing aimlessly through them is out of the question. Your most logical course is to first consult one of the more complete, up-to-date indexes of medical journal literature.

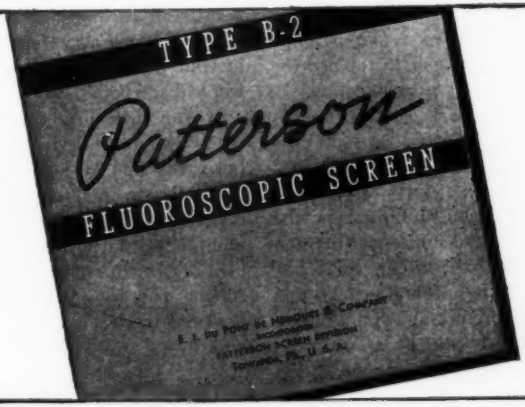
Here you turn either to the Quarterly Cumulative Index Medicus or to the Army Medical Library's Current List of Medical Literature. You look not only under "epilepsy" but also under "convulsions," "grand mal," and the drugs named in other references. Then you pick out the most recent articles and review them. Their authors will have consolidated the earlier literature so that a search back to the days of Galen for complete information is hardly necessary.

Exhaustive Source

Another mine of medical literature is the Index Catalogue of the Library of the Surgeon General's Office. This monumental work is in constant state of revision so that it's never really up-to-date, but it is the most exhaustive bibliographical source available for past literature on medical topics. Its volumes run by letter rather than year and doctors consulting this tome may find it a bit tricky to use. But librarians gloat over its completeness and are anxious to explain the technique involved in using it.

Large medical libraries try to stock every issue of every scientific

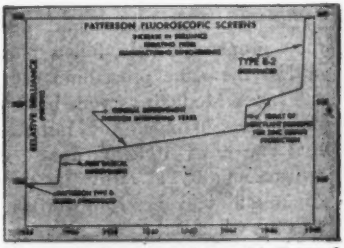
Du Pont **TYPE B-2** a new, more brilliant Patterson Fluoroscopic Screen



TYPE B-2 is a new Patterson Fluoroscopic Screen that gives you 40% more brilliance than the present Type B Screen. It permits a more accurate diagnosis in less time. The new Screen makes use of a radically improved luminescent chemical; marks another milestone of Patterson progress.

The extra sensitivity of the new Type B-2 Screen allows utilization of greater brilliance at customary levels of x-ray energy, or a reduction of energy when the former degree of brilliance is maintained. The Screen gives absolute uniformity and stability to x-rays; has no objectionable after glow, and the increased brilliance does not alter contrast. There is greater visibility of detail, and the Screen is ideal for miniature radiographic work with green-sensitive film.

Complete information about this remarkable new improved Fluoroscopic Screen will be sent on request. Patterson Screen Division, E. I. du Pont de Nemours & Co. (Inc.), Towanda, Pennsylvania.



The graph above shows increased brilliance of the new Type B-2 Screen compared with that of the Type B. Note that the new Screen is three times as bright as the original Type B introduced in 1933.

(Listen to "Cavalcade of America" Monday evenings—NBC)

DU PONT

BETTER THINGS FOR BETTER LIVING
...THROUGH CHEMISTRY

* HANDITIP *

Soles for Heels

I glued a pair of large rubber half soles to the floor mat of my car at the point where the driver's feet usually rest. Now my heels, instead of wearing out the rubber flooring, wear out the soles. I find it much simpler and cheaper to replace the half soles than the whole mat.

—M.D., GEORGIA

* * *

medical journal published in the U.S. They have impressive foreign collections, too. You can, therefore, usually get the original articles you want by presenting your bibliographic list to the librarian. Even small libraries stock enough different journals so that you're able to find many of the references you've copied from the Current List, the Index Medicus, or the Index Catalogue.

In preparing background data for a proposed article, follow more or less the same procedure, using the Index Medicus as your base of reference. Assume, for instance, that you are writing up a case of schistosomiasis, a rarity in your community and therefore worth reporting. Check all recent references in the Index Medicus under "schistosomiasis" and under such related words as "bilharziasis," "trematodes," and "flukes." A rapid reading of each article gives you some idea of how common such cases are. The bibliographies of past articles also serve as springboards for further study. In a case like this, you'll also want to include in your research a standard text of tropical medicine.

If you drift into the library to while away an idle hour, your best bet is the shelf of new books that's generally to be found near the door. Or you can take a short stroll around the stacks to get a general idea of how the books are grouped. As you walk by, titles and topics of personal interest are sure to catch your eye.

Reprint Source

The small-town practitioner who's not near a medical library is by no means condemned to medical illiteracy. He can obtain packages of reprints from a variety of sources, usually for a small service charge plus postage. Best-known source is the package library of the American Medical Association (535 North Dearborn St., Chicago 10). Simply name your topic and send in twenty-five cents. The more sharply you define your subject, the

more suitable the material you'll get. You can't expect a topnotch selection if you ask for "some reprints on arthritis." But if you request material on the "effectiveness of gold salts in the treatment of arthritis," you'll probably receive copy that will hit the subject on the nose.

Reprint packages are also available from many state medical societies and even from some large public libraries. Most of these restrict services to members or to residents of the state. Among the state medical associations offering such service are those in Indiana, Iowa, Maine, Maryland, Ohio, Oregon, Pennsylvania, and Texas.

Special Sources

You can also get literature on request from special libraries (*e.g.*, the National Health Library 1790 Broadway, New York 19); from specialty societies (*e.g.*, the American College of Surgeons), and from organizations in related fields (*e.g.*, the American Dental Association).

Material on all phases of hospital administration may be borrowed

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

from the Bacon Library of the American Hospital Association, 18 East Division St., Chicago 10. It mails out literature on such topics as interne training, nursing care, dietetics, medical records, nomenclature, etc.

You can, in addition, tap the vast facilities of the Army Medical Library through any public, hospital, or university library. For the price of the postage, you can get books, slides, pamphlets, journals, photographs, and microfilms. Write to the Army Medical Library, 7th at Independence Ave. S.W., Washington 25, D.C. to find out what's available in your field of interest. Or tell your local librarian what you want. He'll forward your request to Washington, whence the material will be dispatched on an inter-library loan.

AMA Journal Index

One way to get a bird's-eye view of recent medical literature is to scan the index that appears in the April, August, and December issues of the Journal AMA. The publishers index abstracts as well as original articles, so little material of major importance escapes mention there.

All in all, the books and journals of American medicine comprise the world's greatest storehouse of scientific knowledge. And it's a storehouse whose welcome mat is always out. —HENRY A. DAVIDSON, M.D.

That Doctor's Degree

• How do the requirements and standards differ for doctoral degrees in the various fields of learning? This question, asked on several occasions by readers of MEDICAL ECONOMICS, is answered by Hugh J. McDonald in the Journal of Higher Education. Says he, in essence:

"The conferring of doctoral degrees is in need of a thorough housecleaning. The Doctor of Philosophy (Ph.D.), traditionally the highest degree in our educational system, is being granted in most cases after only three years of full-time study and examination beyond the attainment of a recognized bachelor's degree and the preparation of a thesis setting forth a contribution to knowledge. The degree of Doctor of Science (D.Sc.) is given for an identical program where the major part of the work is in natural, physical, or applied science.

"To meet the ever increasing demand for [*Continued on* 186]

doctors' degrees from high-school teachers, some colleges have instituted a new degree, Doctor of Education, on a standard lower than that of the Ph.D. The residence requirements are about the same as for the latter, but the thesis need not set forth an original contribution to knowledge.

"In the field of health (or should it be called ill-health?) the assortment of doctorate degrees is a wide one. If one 'receives the call' to alleviate pain, one may choose to study for any of the following degrees:

¶ "Doctor of Naprapathy, in about 90 days, with no entrance requirements.

¶ "Doctor of Chiropractic, in one to four years, depending on the school, with the minimum entrance requirement usually being completion of an elementary-school education.

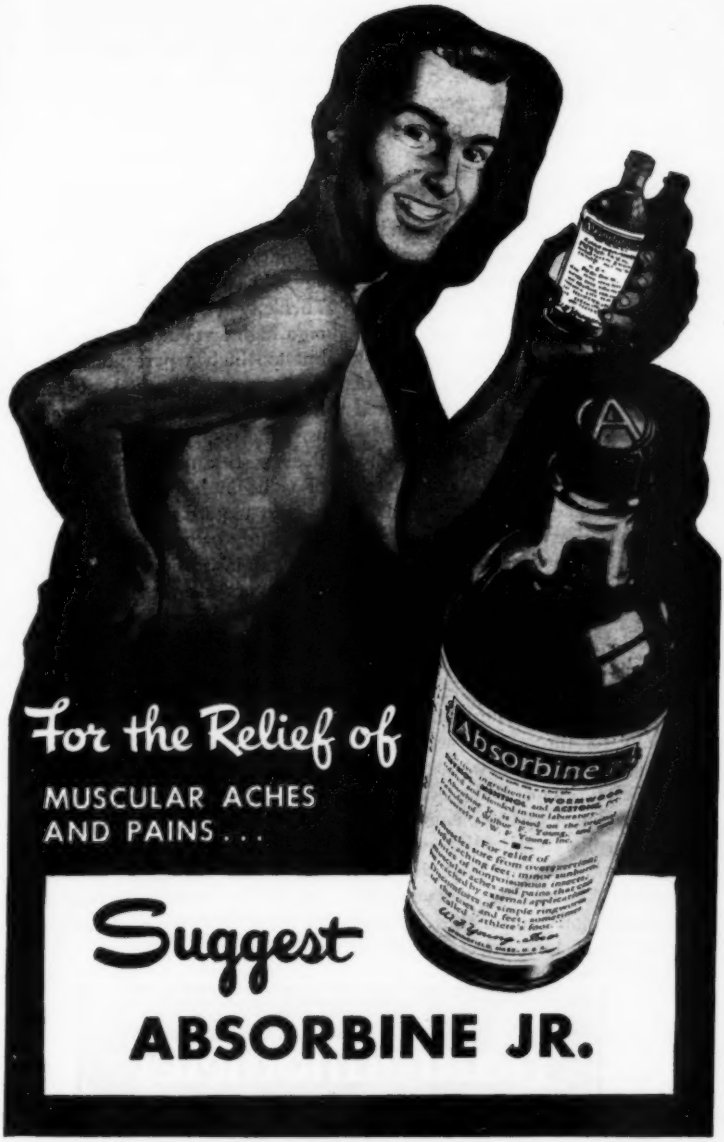
¶ "Doctor of Surgical Chiropody, in eighteen months to three years, the minimum entrance requirement being the same as in the chiropractic field.

¶ "Doctor of Optometry, in three to four years after high-school graduation.

¶ "Doctor of Veterinary Medicine, in four years after completion of one year of general college work.

¶ "Doctor of Dental Surgery or of Dental Medicine in a minimum of three years, with two years' college work, or of four years, with one year's college work.

¶ "Doctor of Osteopathy, in a minimum of four years, with usual-


For the Relief of
MUSCULAR ACHES
AND PAINS . . .
Absorbine
Suggest
ABSORBINE JR.

ly at least one year of college work as prerequisite.

¶ "Doctor of Medicine, requiring a minimum of four years' study, with at least two years' pre-medical training.

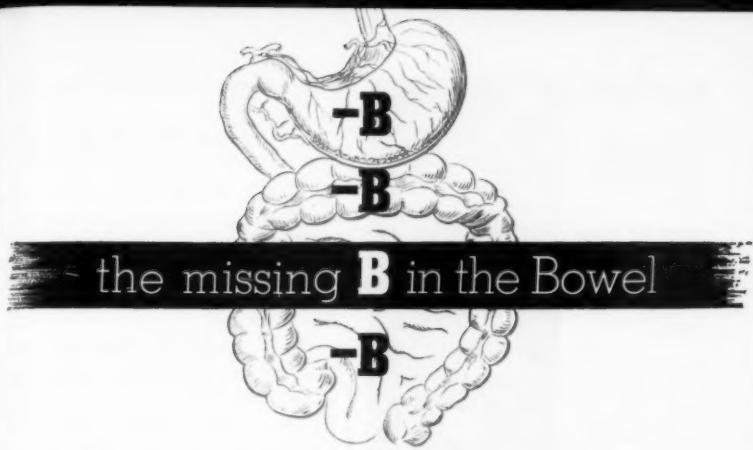
¶ "Doctor of Public Health, usually awarded to holders of the M.D. degree in a year or so, and to graduates in bacteriology or related fields after three years' study.

"For the student in law, several doctorate degrees are now available. On graduation from many law schools the degree of Doctor of Jurisprudence (J.D.) is conferred on those who hold a bachelor's degree in arts, science, or philosophy. In some schools, if the candidate's marks are low, the degree of LL.B. will be conferred on him. To add to the confusion, the degree J.D. usually does not carry with it the right to be addressed as "doctor" and is followed in most schools, on further study, by the degree of Master of Laws (LL.M.). For an intensive study of law on the graduate level, usually for three years' work after obtaining the first law degree, the degree of Doctor of the Science of Jurisprudence (S.J.D.) is available.

"Probably it is in the awarding of honorary degrees that the least discretion is used. Every year our colleges and universities bestow honorary doctorate degrees such as LL.D., (Doctor of Laws), D.Litt. (Doctor of Literature), D.H.L. (Doctor of Humane Letters), D.Sc. (Doctor of Science), and D. Eng. (Doctor of Engineering) to the tune of over a thousand.

"In the field of theology, spurious degrees are more rampant than anywhere else. Degrees of Doctor of Divinity (D.D.), Doctor of Theology, (D.Th.), and Doctor of Sacred Theology (D.S.Th.) are awarded on a high level at most institutions; but too high a percentage of such degrees are acquired at bargain rates of energy expenditure. The aspiring young preacher, deciding that the title of "doctor" would be of value in his profession, finds it easy to acquire such a title by summer study or by correspondence.

"One institution awards dozens of doctors' degrees every year in theology, philosophy, and psychology, after the completion of two or three courses of less than high-school caliber and the payment of about $100. The doctorate has, in fact, been a best seller in the correspondence study field. A so-called "institution of higher learning" in Chicago, run by one man and his wife, has sold many such degrees during the last thirty years. Another outfit in Seattle, Wash., does a thriving business in doctorates by mail."



The close association of gastro-intestinal disorders and frank vitamin B deficiencies has suggested B complex therapy in treating such disorders. Chesley and co-workers,* reporting 72.5% satisfactory results with this therapy, state that: "... vitamin B complex offers more to many patients . . . than any of the regimes of careful dieting, antispasmodics, sedation, etc., now in common use."

more effective B therapy based on liver

The Special Liver Fraction used as the base of Beta-Concemin provides additional B complex factors not available in synthetic mixtures alone—as evidenced by the better weight, development and survival of laboratory animals to whose diet this Special Liver Fraction has been added.

potencies increased

Now the clinically established B vitamins in the Beta-Concemin formula have been strengthened and rebalanced for increased effectiveness—while the addition of choline reflects newer work on the value of this factor in liver conditions. ALL AT NO INCREASE IN PRESCRIPTION COST.

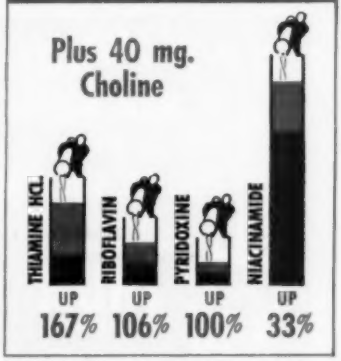
ELIXIR—4-oz., 12-oz., and gallons
TABLETS—bottles of 100 and 1000
CAPSULES with Ferrous Sulfate—bottles of 100 and 1000

"Beta-Concemin" ®

BETA-CONCEMIN

The *DIFFERENT* Vitamin B Complex

FORTIFIED FORMULA



Each fluidounce of Elixir Beta-Concemin now contains 32 mg. Thiamine Hydrochloride, 16 mg. Riboflavin, 8 mg. Pyridoxine Hydrochloride, 80 mg. Niacinamide, 40 mg. Choline Citrate and 4 Gm. Special Liver Fraction. Capsule and tablet potencies increased in same ratio.

*Am. J. Dig. Dis. 7: 24-27 (1940)

MERRELL 1828

THE WM. S. MERRELL COMPANY • CINCINNATI, U. S. A.

Blue Cross [*Continued from* 43]

cy. So far, this boon to subscribers is still in the talking stage. Local variations in economic standards are the big stumbling blocks. But some progress has been made: (See "Top Medical, Hospital Prepayment Agencies Plan Merger," page 60, this issue).

What sends shudders up and down professional spines is the possibility that Blue Cross and the hospitals will exhaust themselves in their current economic conflict. Blue Cross leaders are aware of that danger. That's why the odds favor more expensive hospitalization policies in 1948.

But whether Blue Cross policymakers will boost their rates boldly enough to offset the still-spiraling costs of hospitalization remains to be seen. If they don't, the Blue Cross crisis may be with us for months to come. —C. G. BENSON

Just Published

ARTICLES

WHAT HAPPENS WHEN TRAINED NURSES WON'T NURSE THE SICK? By Gretta Palmer. The answer lies in training more practical nurses, this writer believes. Ladies' Home Journal, December.

BOOKLETS

FACING THE FACTS ABOUT CANCER. By Dallas Johnson. Designed to bring the layman up to date on

Over 1/3 Stronger for Coughs

Exempt Narcotic

Each fluid ounce contains (1) one grain Codeine

MADE with the Codeine *Alkaloid* one grain to the ounce. It is readily verified that 1 grain of Codeine *Alkaloid* is equal in strength to 1.37 grains of the commonly used Codeine Phosphate.

A palatable, cherry-colored syrup, well tolerated by children. Contains with the codeine; ammonium chloride, ipecac, glycerine, sugar syrup, and senna. An exempt narcotic. Costs little or no more than ordinary codeine syrups. Druggists stock for prescription use. *Prescribed since* 1898.

℞

If you will try it —just once—in the coughs of pertussis, bronchitis or asthma you will continue to prescribe it and we shall be grateful.

"Trial is Proof"

Bell's Syrup Codeine Comp.

Meet Percy Phlarge..

Now
Percy was a wise young man
He had an awful ITCH
He knew he shouldn't scratch it
In wisdom he was rich.
Infection comes from scratching
How very well he knewed it!
But—he itched, he scratched,
he bled, fell sick,
And then, moaned he,
"I dood it."

MORAL: He should have consulted his doctor. Soothing the distressing symptom, itching, goes far towards effecting a cure in these irritative, eczematous conditions. Physicians know that ENZO-CAL, the soft, pleasing greaseless cream, with the rose odor, containing semi-colloidal calamine and zinc oxide with benzocaine, will promptly relieve the itching, protect the inflamed skin and aid healing.

for prompt relief of itching

A PRESCRIPTION PRODUCT of Crookes LABORATORIES 205 EAST 45TH ST. NEW YORK 17, N. Y.

ENZO-CAL

+ CLEANLINESS and CONVENIENCE
+ PROTECTIVE, HEALING ACTION
+ FREEDOM FROM GREASE

2 oz. tubes and 1 lb. jars. Literature and samples to physicians on request.

medical progress in the realm of cancer. Points up the importance of periodic examinations and detection centers. 32 pp. Public Affairs Committee, New York. 20 cents.

BOOKS

ALBERT SCHWEITZER, AN ANTHOLOGY. Edited by Charles R. Roy. 324 pp. Harper, New York. $3.75. ALBERT SCHWEITZER: THE MAN AND HIS MIND. By George Seaver. 346 pp. Harper, New York. $3.75. PROPHET IN THE WILDERNESS: THE STORY OF ALBERT SCHWEITZER. By Hermann Hagedorn. 222 pp. Macmillan, New York. $3. Two biographies and a collection of his writings pay tribute to an outstanding missionary-physician.

AMIABLE AUTOCRAT. By Eleanor M. Tilton. A biography of Oliver Wendell Holmes. 470 pp. Henry Schuman, New York. $5.

FREUD: HIS LIFE AND MIND. By Helen W. Puner. The tables are turned in a psychoanalysis of Doctor Freud. 360 pp. Hoswell, Soskin, New York. $4.

SEXUAL BEHAVIOR IN THE HUMAN MALE. By Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin. Based on a scientific cross-section of more than 12,000 case histories, this monumental study confirms many widely held theories, shatters even more. 804 pp. Many tables and charts. W. B. Saunders, Philadelphia. $6.50.

SUCCESSFUL MARRIAGE. Edited by Morris Fishbein, M.D., and Ernest W. Burgess. A guide to marriage problems. 568 pp. Doubleday, Garden City. $6.

WOMEN DOCTORS TODAY. By Sally Knapp. The distaff side in various specialties is described via twelve biographical sketches. 184 pp. Thomas Y. Crowell, New York. $2.50.

MEDICINE FOR MODERNS. By Frank G. Slaughter, M.D. The lowdown on psychosomatic medicine, written for laymen. 246 pp. Messner, New York. $3.50.

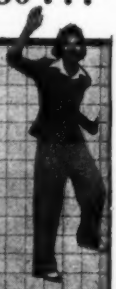
THE MIND IN ACTION. By Eric Berne, M.D. In a series of case histories, the author shows the layman how Freudian psychoanalysis works. 352 pp. Simon & Schuster, New York.

ON HOSPITALS. By S. S. Goldwater, M.D. Essays on hospital planning by New York's former Commissioner of Hospitals. 396 pp. Illustrated. Macmillan, New York. $9.

140 MILLION PATIENTS. By Carl Malmberg. The former research director for a Senate subcommittee on health discusses the maldistribution of medical care, plumps for comprehensive national health insurance. 254 pp. Reynal & Hitchcock, New York. $2.75.

Tampax solves a problem:

36 × 2 × 365 = 26,280 . . .



In what probably is the most comprehensive clinical study yet made of intravaginal tamponage, an exhaustive check* was made on 42 women over a five-year period—36 of whom inserted Tampax *twice daily for an entire year*, using 730 tampons each, for a grand total of 26,280! . . . As a result of this extraordinarily vigorous application (far exceeding normal periodic use of catamenial tamponage), these—among other—highly significant conclusions are drawn:

1. *Tampons (Tampax) are comfortable and help the psychological attitude toward menstruation.*
2. *Tampons (Tampax) overcome menstrual odor.*
3. *Tampons (Tampax) do not irritate vaginal tissues.*
4. *Tampons (Tampax) do not block the menstrual flow.*
5. *Tampons (Tampax) do not cause cancer, erosion or vaginitis.*

Stemming as they do from a notably detailed series of clinical observations, and amply supported by vaginal biopsies, vaginal pH and glycogen determinations, bacteriologic studies and gross visual and pelvic examinations—these conclusions are strikingly corroborative of the safety, adequacy, comfort and convenience of Tampax!

*West. J. Surg., Obst. & Gyn., 51:150, 1943

. . . and gives a new freedom to the menstruant woman!

TAMPAX

THREE ABSORBENCIES
"Regular", "Super" and "Junior"

TAMPAX INCORPORATED, Palmer, Massachusetts

☐ Send samples and literature, including above clinical study.

☐ Quote prices on Tampax for office use. MP-52

Name _____
Please Print

Address _____

City _____ *Zone* _____ *State* _____

The Newsvane

M.D.'s Warned to Stick to Their Lasts

Doctors will avoid trouble on the witness stand if they stick to their own field and avoid sweeping opinions based on non-medical factors. That's the view of John G. Madden, Kansas City attorney, who recently gave members of the Missouri Medical Association a good-humored lecture on their forensic shortcomings.

In case of an injury to a limb, said Mr. Madden by way of example, the doctor may express an opinion on the percentage of loss of use; but he should refrain from estimating how the injury will affect the patient's livelihood. In the latter instance, said the attorney, the physician invades the jury's realm:

"Let me give an example—the 'Case of the Honest Butcher.' This poor fellow, in a moment of inadvertence, severed his left thumb at the first joint with a cleaver. He thereupon asserted that he was ruined for life. Three medical witnesses, after listening to a recital of his manifold duties, expressed the opinion that the loss disabled the Honest Butcher from performing each and every duty.

"The defense promptly produced another Honest Butcher, the highest paid member of his craft in the community, who had discharged all the duties of his vocation for some forty years with the entire left hand severed at the wrist."

Dewey Sponsors Cash Sickness Benefits

Gov. Thomas E. Dewey wants a sickness-indemnification system for New York State similar to plans operating in Rhode Island and California. His industrial commissioner, Edward Corsi, has been working on a bill designed to make cash benefits available for all workers, including state employes.

Future U.S. 'Monkey House of Morons'

If human breeding continues uncontrolled, the U.S. will be "a nation of high-grade morons ruled by the few surviving clever people" in the year 2100, says Dr. Walter B. Pitkin. That means, adds the educator, that "America will be no

more a democracy than any other monkey house." His comments intrduce a new edition of "Human Breeding and Survival" by Burch and Pendell, who advocate compulsory sterilization of the unfit and voluntary sterilization of normal persons who want to limit the size of their families.

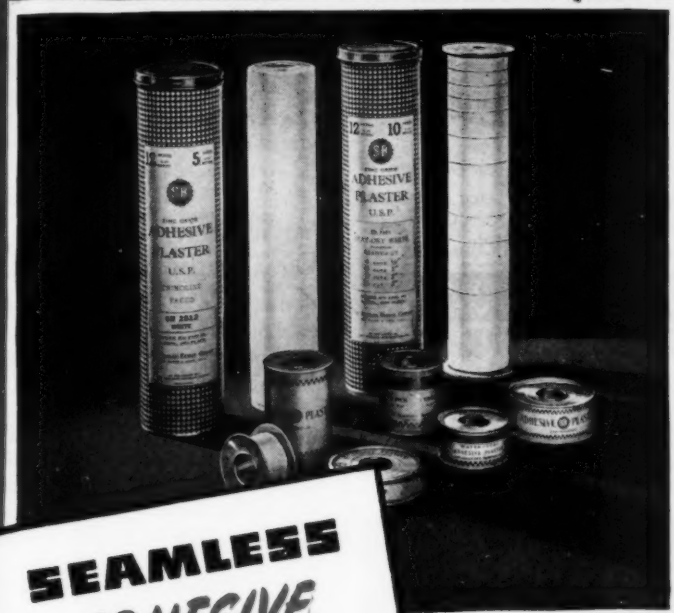
Society Pokes Fun at G.P. Certification

"Maybe Doctor Jones don't know so much, but he knows what he knows and he knows what he don't know. And he ain't afraid to say so, neither. When my girl got a mastoid he sent me to a man who cured her. That's the kind of a doctor I want."

Such a lay appraisal of a general practitioner is sound, says the New York State Journal of Medicine; but it takes a dim view of the future: "If he wishes to get his patients admitted to the hospitals, he must now qualify as a general practitioner. Poor wretch. That is what he thought he had been for many years.

"Now the hospital trustees, guided by the omnipotent and omnipresent AMA and ACS, tell him he must go far away and take an examination by a Board of General Practitioners. And who are the general practitioners who are to examine the general practitioners?

"The AMA resolution reads: 'The criterion of whether a physician may be a member of a hospital staff should not be dependent on certification by the various specialty boards or members in special societies.' [*Continued on* 198]



SEAMLESS ADHESIVE PLASTER

ADHESIVE THAT STAYS PUT!

Summer or winter—dry or moist—SEAMLESS adhesive stays put. Unaffected, it "sticks" to its purpose and adheres firmly until removed. The adhesive mass is highly purified to free it from possible irritants. *That means skin protection!* . . . You have both performance and purposeful quality—the perfect combination! *Users of SEAMLESS products appreciate the difference!* . . . Sold exclusively through selected Surgical Supply Dealers . . . Regular or Stay-Dry. Sectional rolls 12″ x 10 yards and 12″ x 5 yards—in uniform or assorted widths.

REG. U. S. PAT. OFF.

SR

FINEST QUALITY SINCE 1871

SURGICAL DRESSINGS DIVISION

THE SEAMLESS RUBBER COMPANY

"Mark the masterly use of *should*. Perhaps they shouldn't but they will be. We can see already the cocked eyebrow of the diplomate as he mentions to a trustee the unfortunate, parchmentless condition of a rival candidate."

Provide Scientific, Not War Training: Bortz

Let the nation drop the idea of universal military training in favor of a vast program of scientific education, AMA President Edward L. Bortz suggests. He believes the atomic bomb has nullified the value of "large armies, large navies, and individual gunfire." The security of the country rests in the hands of its scientists, not its soldiers, he declares.

"Unfortunately, we cannot brush aside the possibility of another war," says Doctor Bortz. "The best way to avoid it is to train our youth and our citizens, to condition all of them for the part each one may be called upon to play. This need carries directly to our schools."

SMA Relaxes Ban on Negro Doctors

Admission of Negro doctors to the Southern Medical Association's scientific meeting, held recently in Baltimore, may have averted an "incident," say Southern physicians. But it does not mean the SMA is ready to open its membership rolls to colored doctors. Prior to the meeting, a group of Balti-

Sal Hepatica

acts by simple osmosis, to increase the bowel's fluid content and soften fecal residue.

Gentle fluid bulk

produced by Sal Hepatica evokes peristalsis and evacuation by normal physiologic means.

APERIENT

LAXATIVE

CATHARTIC

PRODUCT OF BRISTOL-MYERS • 19 WEST 50 STREET • NEW YORK 20, N.Y.

more physicians protested the association's exclusion policy. Dr. E. L. Henderson of Louisville, SMA president, then changed the wording of the invitation so that "any licensed physician" could attend the sessions.

New York City Poor in Teaching Hospitals

New York City, often thought of as America's medical Mecca, is actually a poor place for graduate training of physicians. So says the Hospital Council of Greater New York. After having surveyed nine of the largest cities, the council places New York eighth in clinical facilities. Far too many of the city's hospitals are so small (less than 200 beds) that they are not suitable for residencies, the council points out.

St. Louis is cited as an antithetical example. In the fields of ophthalmology, gynecology, plastic surgery, and ENT, it has more teaching hospitals in ratio to population than New York, Baltimore, Boston, Philadelphia, Cleveland, Chicago, Detroit, or Los Angeles. It ranks second in general medicine, general surgery, pediatrics, obstetrics, urology, and thoracic surgery.

Urges Rural Laymen to Help Doctors

"Doctors and Horses," a booklet prepared by the Illinois State Medical Society, calls on the rural population to help prevent the country

doctor from going the way of the farm horse. It suggests that doctors and laymen form a health council in each community.

The council's job, says the society, would be to "stimulate public interest in sanitation and health; spread the gospel of preventive medicine; help establish local health agencies and programs; plan for financing, erecting, and maintaining hospitals; set up ambulance services, and recruit doctors and nurses."

The council would act as middleman between the medical profession and the public, the society says, adding that the council might be particularly valuable in getting hospital construction funds under the Hill-Burton Act.

Half a Million Nurses Seen Needed in 1960

If today's nursing standards prevail in 1960, about 500,000 R.N.'s will be needed to fill all demands. But if optimum service is to be provided, a million nurses will be needed, or about three times the current number. That's the conclusion of the Women's Bureau of the Department of Labor, which conducted a study for the Presidential Commission on Higher Education.

Prospects of achieving the 500,000 mark are not considered good. Last year's production of new nurses was 44,700, the largest ever. But with suspension of the wartime Cadet Nurse Corps program, the increment in 1948 will be 37,700;

in 1949, 20,600; and in 1950, 26,700. The bureau estimates that from 1951 onward the nation will have to produce about 43,000 nurses a year to reach its goal.

The AMA says there is a current shortage of 42,000 R.N.'s, and that probably 60,000 more will be needed as new hospitals are completed. It points out that the nation had 1,226,000 hospital beds in 1940, 1,738,000 in 1945, and that construction under the Hill-Burton Act is just starting.

Drug Industry Launches New Research Plan

The drug industry of the United States, which last year spent $50 million on research, will foot the bills of the newly formed Pharmaceutical-Medical Research Foundation to the tune of $225,000 per year.

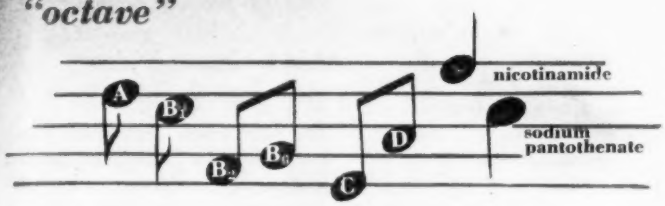
Co-sponsored by the AMA and the American Pharmaceutical Manufacturers Association, the unit will first tackle research in the degenerative diseases, emphasizing those of the heart, blood, and kidneys. Most of the PMRF funds will go to groups already studying these problems.

Idea for the new foundation came from Charles Wesley Dunn, general counsel for the food and drug industry, who in 1941 was instrumental in starting the Nutrition Research Foundation.

Public Hears About Hospital Crisis

More and more hospitals, squeezed by rising costs and a declining bed census, may take their troubles to the public. Two campaigns—one in Minneapolis-St. Paul, the other in Cincinnati—have demonstrated that laymen have only a vague idea of what hospitals are up against. What's more, the public shows surprising interest in learning the facts.

At the request of Twin City institutions, the Minneapolis Star assigned a reporter to an independent investigation of hospitals. Results were presented in a series of front-page articles that evoked wide interest. They pointed out that costs had risen from $5.75 per patient-day in 1941 to $12.50 in 1947. They showed that nurses and



concerted action of 8 vitamins when you prescribe

ABDEC® *drops*

ABDEC DROPS, in harmony with their wide range of therapeutic and prophylactic indications, supply eight important vitamins in a clear, non-alcoholic solution—vitamins A, B_1, B_2, B_6, C, D, nicotinamide and sodium pantothenate. They are used most effectively for the infant in the first crucial months of existence and for the growing child.

ABDEC DROPS may be placed directly on the tongue or added to milk, fruit juices, soups, cooked or pre-cooked cereals and other foods. The full daily dose is preferably given at a single feeding. The average daily dose for infants under one year is 0.3 cc. (5 minims); for older children, 0.6 cc. (10 minims).

ABDEC DROPS are supplied in 15-cc. and 50-cc. bottles with a special graduated dropper to facilitate accurate dosage.

Each 0.6 cc. (10 minims) of **ABDEC DROPS** contains vitamin A, 5000 units; vitamin D, 1000 units; vitamin B_1, 1 mg.; vitamin B_2, 0.4 mg.; vitamin B_6, 1 mg.; pantothenic acid (as sodium salt), 2 mg.; nicotinamide, 5 mg.; vitamin C, 50 mg.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

MEDICAMENTA VERA

other employes were demanding higher wages and shorter hours, that the burden had to be passed on to the patient.

In Cincinnati, a Blue Cross survey evoked opinions like this one, from a business man: "I think the charges made by hospitals are outrageous. While most may be operating at a loss, there must be an element of inefficiency somewhere." At a public meeting that followed, Everett W. Jones of Modern Hospital made headlines when he accused the public of being unfair. It was willing, he said, to pay $3.50 for a $1.50 dinner, or $25 a day for a Florida hotel room, but resented paying $10 a day for hospital service, "which begins where hotel service leaves off."

Fleecer of M.D.'s Seized in N.Y.

A Toronto stock promoter who allegedly preyed on U.S. doctors was recently seized in New York by Federal authorities. They charged that he specialized in selling worthless stock in tantalum mines, doing his business with physicians via letters and telephone calls.

The suspect is Albert Edward De Palma, alias Albert Edward Zucker, alias Charles Bronson. He is said to have reaped $3 million in his U.S. operations. He owns a $250,000 home in Toronto.

AMA Charts Video Showmanship

The AMA's new "Television Handbook" provides briefing for medical societies and doctors who plan video programs on public health. It describes the possibilities and limitations of television, plus its basic techniques. And it gives a thumbnail description of twenty-eight successful shows.

Physicians Forum May Admit Lay Members

The Physicians Forum, a leading Wagner-Bill supporter, has been toying with the idea of opening its membership rolls to all persons—lay or professional—who are "concerned with health problems." Bringing in dentists, nurses, public health workers, and others might, it feels, stir up more activity in communities "where we now have an isolated physician or two."

Forum members who don't favor letting down the membership bars suggest instead the formation of a "health section" in a group like Progressive Citizens of America or Americans for Democratic Action.

[*Continued on* 208]

Dr. Channing Frothingham, long a leading figure in the Forum, thinks it might be better to merge with the Committee for the Nation's Health (of which he's chairman), thus obtaining support "from as broad a base as possible."

Eye Bank Reports 2nd Year Expansion

The Eye-Bank for Sight Restoration collected 600 eyes in its second year of operation, distributed 90 per cent of them for corneal transplantation. The bank reports that it now has 150 hospital affiliates plus branch banks in Boston and New Orleans. A vast factor in its success, says the bank, has been the continued cooperation of newspapers (which publicize its need for eyes) and of the air lines (which transport them without charge).

Medical Practice Act Hit by Cultists

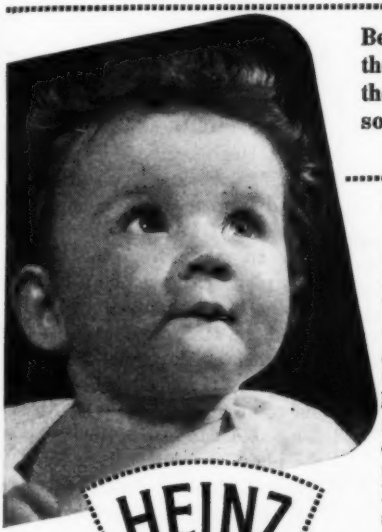
Chiropractors and naturopaths recently asked the Federal Court in Newark, N.J., to declare the state's medical practice act null and void. They asserted that the act creates a "monopoly" for physicians and permits the state licensing board to make discriminatory regulations. They claimed the board sends out "spies" to trap them in violations of the law.

Joseph W. McGillvary of Bayonne, co-plaintiff with the state chiropractic association, had charges of illegal practice pending against him at the time. So also had Joseph J. Tuliglowicz of Maplewood, co-plaintiff with the state naturopathic society. He had previously been convicted of illegal medical practice in 1924, 1927, and 1940.

Asks Full-Scale Attack on the Common Cold

The age-old mystery of the common cold can be solved only by the kind of "mobilized research" that produced atomic fission, says Dr. Noah D. Fabricant of the Illinois University College of Medicine. He wants "piecemeal" research abandoned in favor of a unified program carried on by qualified workers in medicine, chemistry, biology, pharmacology, physiology, bacteriology,

For Your Important Young Patients



Because only the finest foods on the market are good enough for the infants in your care, you—like so many doctors—recommend *Heinz* Baby Foods!

YOU men of the medical profession know, better than anybody, the important part high-quality foods play in baby's growth. And we of H. J. Heinz Company can *assure* you that the skill of 79 years goes into making Heinz Baby Foods as uniform as possible.

Heinz Strained Pears and Pineapple furnishes a typical example of this conscientious care! For Heinz chefs use choice Bartlett pears and select Hawaiian pineapple—cook, strain and pack them scientifically.

You can confidently recommend Heinz Strained Pears and Pineapple. Like all Heinz Baby Foods, it's backed by a famed quality tradition.

HEINZ
STRAINED
PEARS AND
PINEAPPLE

57 VARIETIES
MADE BY
H. J. HEINZ COMPANY

All Heinz Strained Fruits—Peaches, Prunes, Apple Sauce, Apricots and Apple Sauce—have fine flavor, rich color and smooth texture that appeal to babies!

HEINZ BABY FOODS

CEREALS • FRUITS • VEGETABLES
MEAT FOOD PRODUCTS • DESSERTS

pathology, engineering, and architecture.

He foresees no difficulty in getting funds from public and private sources once the project is organized. Then, says Doctor Fabricant, "decades of individualistic groping" may be telescoped into "years of cooperative endeavor."

Deadlock Continues Over Compulsory Plan

The stalemate between San Francisco's Health Service System and the 950 physicians who had resigned from it was still in force a month ago. The doctors, who withdrew *en masse* from the compulsory plan in November, told the 12,000 city employes who comprised the HSS membership they'd treat them at any time—but as private patients, not as subscribers to the controversial plan. Dr. Alexander S. Keenan, medical director of the plan, complained that the doctors had "gone on strike," that they had abandoned their medical ethics in declining to treat HSS members under the terms of the system. The physicians retorted that there was

Patients, or doctors, kicking like steers because they're kept awake by the caffein in coffee...

can drink delicious, caffein-free Sanka Coffee and sleep like lambs—

SANKA COFFEE

All coffee—real coffee—delicious coffee
97% caffein-free

NOW! Sanka comes in *two* forms! New Instant Sanka as well as your favorite grind for percolator or drip.

Products of General Foods

TUNE IN! The Hilarious NEW Sanka Coffee Show—starring funster Danny Thomas! CBS, Fridays, 8:30 p. m., E. S. T.

no thought of striking against patients, but simply against a system that was "actuarially unsound, has been losing money for a year, and today is virtually insolvent."

Doctor Keenan had appealed to doctors who were not members of the San Francisco County Medical Society to come into HSS. This invitation excited little interest, since all but two of San Francisco's hospitals demand membership in the county society as a prerequisite to admission to the staff. If Doctor Keenan succeeded in recruiting some non-society members for the HSS panel, observers said, he would still be unable to get his patients in any except two small, unrecognized institutions.

California Physicians Service was staying out of the San Francisco controversy, though HSS officers had charged that local physicians were trying to force HSS subscribers into the statewide, voluntary plan. But even though CPS was not angling for this group, there was talk that the Permanente Foundation was doing so. Its medical director, Dr. Sidney Garfield, was reportedly conferring with HSS directors.

The 950 physicians had made it clear they didn't intend to return to HSS until the plan abandoned its compulsory membership feature. HSS officers claimed that would take an amendment to the city-county charter. Last month no one was making any move to introduce such an amendment.

Where to Find Our Advertisers

WEAK ARCH

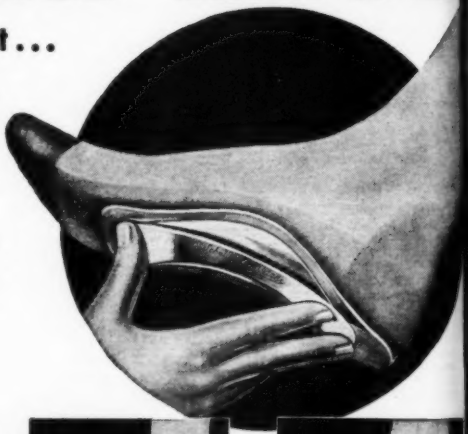
Tired, Aching Feet...

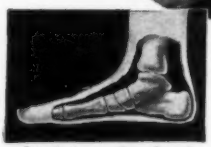
Rheumatoid Foot and Leg Pains...

Sore Heels...

Excessive Fatigue

Quickly Relieved This Simple, Scientific Way with Dr. Scholl's FOOT-EAZER





A typical case of weakened Longitudinal Arch

How Dr. Scholl's Foot-Eazer helps reposition Arch structure

THESE symptoms, so common among persons who walk or stand for the most part during their working hours, are quickly relieved when patients are fitted with Dr. Scholl's Foot-Eazers. By easing muscular and ligamentous strain of the weakened arch structure, Dr. Scholl's Foot-Eazers promptly relieve the sufferer's distress. They are thin, light, flexible and adjustable as condition of the arches improves. Expertly fitted at Shoe and Department Stores and at Dr. Scholl Foot Comfort* Shops in principal cities. $5.00 pair. Professional literature gladly mailed on request.

Dr Scholl's FOOT-EAZER

Dr. Scholl Foot Comfort Shops are located in the following cities:

Albany, Baltimore, Boston, Bridgeport, Brockton, Buffalo, Canton, Chicago, Cincinnati, Cleveland, Columbus, Dayton, Denver, Detroit, Duluth, Elgin, Fargo, Fort Wayne, Glendale, Grand Rapids, Hammond, Harrisburg, Hartford, Hollywood, Indianapolis, Jamaica, Kansas City, Long Beach, Calif., Los Angeles, Milwaukee, Minneapolis, Muskegon, New Haven, Newark, New York, Oakland, Omaha, Peoria, Plainfield, N. J., Philadelphia, Phoenix, Rochester, St. Louis, St. Paul, San Bernardino, San Diego, San Pedro, Schenectady, Scranton, Seattle, Spokane, Springfield, Ill., Springfield, Mass., Syracuse, Toledo, Trenton, White Plains, Wilkes-Barre, Wilmington, Worcester, Toronto.

See Classified Telephone Directory

*Trade Mark Reg.

For name of dealer in your community write THE SCHOLL MFG. CO., Inc., Chicago—New York